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Return to Churn: The Impact of Medicaid Unwinding on Access to Adult Immunizations

Contents

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Introduction

Adult vaccination rates are lower for uninsured vs. insured adults (e.g., 19.5% vs. 44.1%, respectively, for influenza vaccines), suggesting insurance coverage could be a key factor driving vaccination behavior.[1] Further, vaccination rates vary by insurance coverage type; for example, vaccination rates for Medicaid enrollees are often lower than for their privately insured counterparts.[2] While additional factors like hesitancy continue to affect vaccination rates, studies indicate that costs associated with being under- or uninsured are often at the forefront of individual vaccination decisions.[3]

The COVID-19 public health emergency (PHE) provides a natural experiment to show how insurance coverage gain or loss could affect vaccination rates. Policies enacted during the PHE extended Medicaid beneficiaries' enrollment for several years, and then, through an "unwinding" process, states resumed eligibility determinations. Subsequently, Medicaid enrollment declined nationwide by about 10 million individuals within 12 months.

While the impact of unwinding on enrollment is clear, its impact on access to healthcare services—specifically, to vaccination—is less certain. There is some public reporting of vaccination rates among Medicaid-enrolled populations, but state-by-state variation in Medicaid program management, data reporting, and presentation may limit our understanding of long-term trends, both nationwide and at the state and local levels. Further compounding these challenges are provisions in the recently passed One Big Beautiful Bill Act (OBBBA) of 2025 requiring Medicaid programs to conduct eligibility redeterminations every six months (many states allow 12 months or more between redeterminations), implementing work requirements for certain adults, and changing federal financing guidelines.[4] These provisions could intensify vaccine access challenges potentially associated with unwinding and declining Medicaid enrollment immediately following the COVID-19 PHE.

To understand the current policy environment and potential future implications, this white paper examines the Medicaid policies enacted during the COVID-19 PHE, their unwinding, and how these milestones could affect vaccine access for Medicaid enrollees.

Background

Churning, defined as the process by which Medicaid beneficiaries move in and out of coverage, was a common phenomenon throughout the first 55 years of the program. It is associated with care disruptions, including missed preventive services like screenings and immunizations, as well as discontinuation or postponement of treatment due to costs.[4,5] The cycle of disenrollment and reenrollment also results in higher administrative costs borne by states.[6]

During the COVID-19 PHE, the US government developed and implemented policies to ensure access to COVID-19-related healthcare services without cost sharing and expand and continue healthcare coverage for certain populations. Specifically, one of these policies paused eligibility redeterminations for Medicaid enrollees. While states typically conduct Medicaid redeterminations annually or more often, this

policy enabled people to remain enrolled in Medicaid coverage throughout the PHE, temporarily eliminating churning.

With continuous enrollment, Medicaid beneficiaries were able to maintain access to healthcare services beyond those related to COVID-19, including access to routine adult vaccinations without cost sharing. However, beginning April 1, 2023, states had the option to either immediately initiate or gradually resume, over a period of up to 14 months, eligibility redeterminations.[7] This was known as “unwinding” the continuous enrollment.

While processes varied by state, the result was a Medicaid enrollment decline of approximately 10% nationwide from April to December 2023.[8] Since then, enrollment has continued to decline; from January to October 2024, enrollment decreased an additional 7%.[9] The proportion of disenrolled individuals that successfully enrolled in other health insurance coverage varies by state, though many individuals became uninsured.[10] While implementation of the Inflation Reduction Act (IRA) introduced additional vaccine coverage requirements in October 2023, these provisions did not apply to uninsured adults.[11]

Medicaid basics

The Medicaid program, established in 1965 as Title XIX of the Social Security Act, is a joint federal and state program that gives states flexibility in eligibility and service coverage decisions.[12] While each state has some authority to administer its respective program, the federal government sets certain requirements for state programs to follow, including 17 categories of mandatory benefits (e.g., hospitalization, physician services, and childhood immunizations administered as part of Early and Periodic Screening, Diagnostic, and Treatment services) in order to receive federal funding and use the Centers for Medicare and Medicaid Services (CMS) apparatus.[13] States may also cover any of 30 categories of optional benefits (e.g., prescription drugs).[14] All 50 states, DC, and the US territories have Medicaid programs.

Medicaid was created with the goal of providing quality medical care to low-income families who could not afford coverage.[15] Within the first five years of implementation, insurance coverage increased by about 2%, and Medicaid eligibility later expanded beyond families with children to include older adults and people with disabilities.[16] The program’s benefits were particularly noticeable among non-white children; for example, child mortality fell 20% among non-white children enrolled in Medicaid soon after the program’s introduction.[17] These mortality reductions along racial and socioeconomic lines were attributed to access not only to insurance coverage, but specifically to infectious disease care.[18]

Additionally, the Children’s Health Insurance Program (CHIP) provides coverage for children. Like Medicaid, CHIP is jointly funded by states and the federal government. Eligible children are in families with incomes too high to qualify for Medicaid but too low to reasonably afford private insurance coverage.[19]

Financing

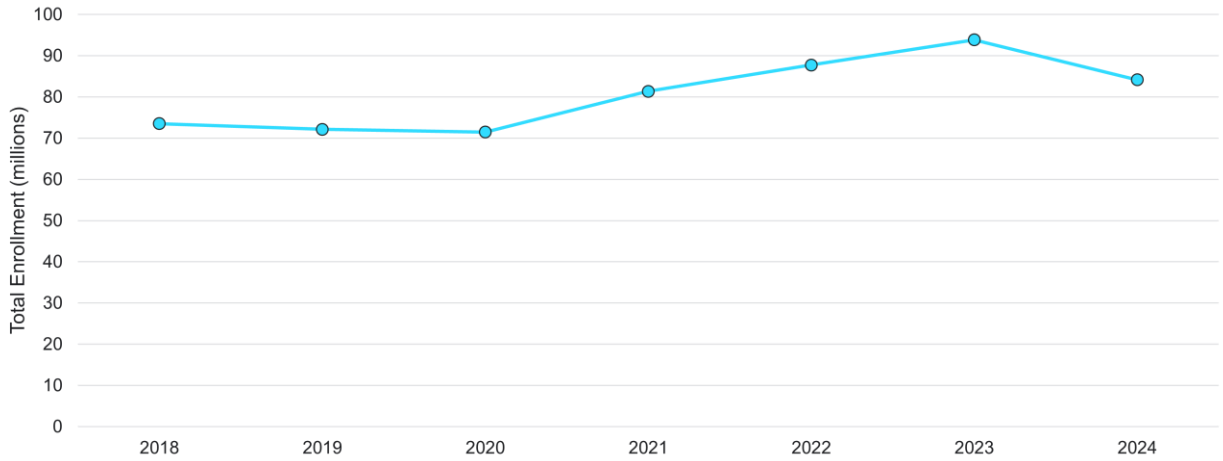
States manage Medicaid programs, but costs are shared between states and the federal government. CMS matches a portion of each state's Medicaid costs based on its Federal Medical Assistance Percentage (FMAP), which is based on the state's per capita income and ranges from 50% to 83%.[20,21]

Eligibility and enrollment

To be able to enroll in Medicaid, an individual must meet certain eligibility criteria and financial guidelines, which vary by state. Eligible groups generally include children, pregnant people, families, individuals with disabilities, and older adults.[22] The 2010 passage of the Affordable Care Act (ACA) allowed states to expand Medicaid eligibility to adults aged 19 to 64 years with incomes below 138% of the Federal Poverty Level (FPL), leading to increased coverage and decreased churning among adult Medicaid enrollees.[23,24] Prior to this law, eligible groups had to meet strict income requirements (e.g., parents often had to have incomes lower than 64% FPL), which enrollees may periodically exceed, resulting in churn.[25]

In December 2019, there were 71.3 million Medicaid and CHIP enrollees nationwide, 36% of whom were children, 40% adults (excluding older adults and adults with disabilities), and 14% adults with disabilities.[26,27] During the PHE, Congress passed the Families First Coronavirus Response Act (FFCRA) in March 2020, under which states received an increased FMAP in exchange for being prohibited from disenrolling people from Medicaid.[28] By the end of this continuous enrollment period on March 31, 2023, national enrollment peaked at about 94.2 million.[29,30] Between the beginning of Medicaid unwinding in April and October 2024, Medicaid enrollment declined by approximately 15 million people, a 16.1% decrease (Figure 1).[31]

Figure 1. Total Medicaid enrollment, 2018-2024[32]



Historical Medicaid vaccination rates

In general, vaccination rates are lower for both adult and child Medicaid beneficiaries than for individuals covered by private insurance. Further, vaccination rates vary across geography, gender, ethnicity, race, and other demographic characteristics. A 2022 Medicaid and CHIP Payment and Access Commission report demonstrated that adult vaccination rates were lower for Medicaid enrollees than for privately insured individuals across several vaccine types, with additional variability by race and ethnicity (Table 1).[33]

Table 1. Adult* vaccination rates by vaccine type, insurance coverage market, and race/ethnicity, 2015-2018[34]

Vaccine type	Coverage market		Race/ethnicity					
	Private	Medicaid/ CHIP	White	Black	Hispanic	Asian	AI/AN	Other
Influenza	40.8%	32.8%	30.9%	31.5%	34.2%	40.5%	52.4%	52.4%
Td	66.7%	56.7%	64.9%	46.4%	53.4%	43.5%	63.0%	61.3%
Tdap	35.2%	22.6%	30.1%	15.9%	17.9%	16.8%	22.9%	26.1%
Pneumococcal	13.3%	16.9%	18.7%	16.9%	15.3%	13.3%	17.5%	14.2%
Shingles	12.8%	7.4%	8.2%	5.4%	6.2%	9.3%	12.0%	9.7%
Hepatitis A	20.6%	16.9%	16.1%	15.0%	17.5%	25.3%	17.1%	19.3%
Hepatitis B	38.8%	33.7%	34.9%	30.0%	33.1%	35.7%	37.0%	42.3%
HPV	36.0%	32.6%	34.5%	30.9%	31.7%	30.6%	N/A	27.6%

*Includes all non-institutionalized individuals aged ≥19 years regardless of coverage source. Medicaid/CHIP excludes individuals with Medicare or private coverage. For the shingles vaccine, the analysis was limited to adults aged ≥50 years; for HPV, the analysis was limited to adults aged 19-26 years.

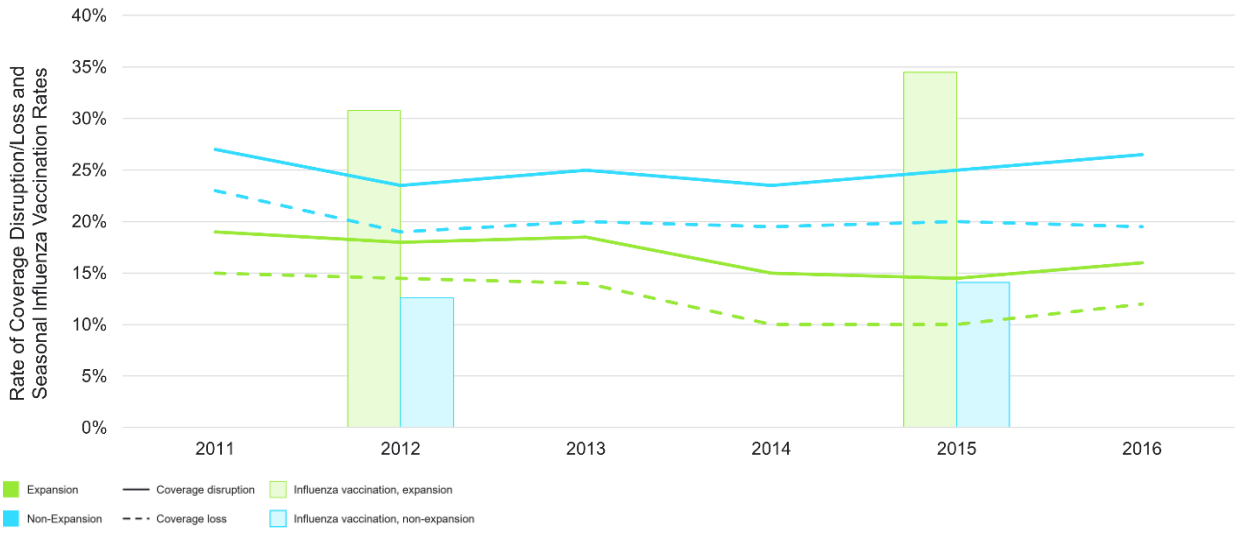
AI/AN: American Indian/Alaska Native; HPV: Human Papillomavirus; Td: Tetanus, Diphtheria; Tdap: Tetanus, Diphtheria, Pertussis

Federal law requires all Medicaid programs to cover vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) without cost sharing. Specifically, the ACA requires states that expanded Medicaid to cover all ACIP-recommended vaccines without cost sharing; this meant that adults who were newly eligible for Medicaid coverage under the expansion could also receive recommended

vaccinations without paying out of pocket (OOP).[35] The ACA does not require vaccination coverage for adults enrolled in traditional Medicaid (vs. expanded Medicaid) to be available at no OOP cost.

Medicaid expansion had an observed impact on vaccination rates among Medicaid-enrolled adults. While there are challenges associated with assessing year-over-year vaccination rate trends for Medicaid enrollees specifically, one study focused on women in Medicaid expansion states found that influenza vaccination rates increased from 30.8% in 2012-2013 (prior to expansion) to 34.5% in 2014-2015 (following implementation), a 3.7 percentage point increase.[36] This study also found that influenza vaccination rates in non-expansion states were lower overall and increased less (12.6% to 14.1%).[37] This could be attributed in part to lower rates of coverage disruption (e.g., gaps in insurance coverage or changes that result in different provider networks and/or coverage) and coverage loss in expansion states compared with non-expansion states (Figure 2). By the time the COVID-19 pandemic was declared a PHE in January 2020, 35 states and DC had implemented Medicaid expansion.[38]

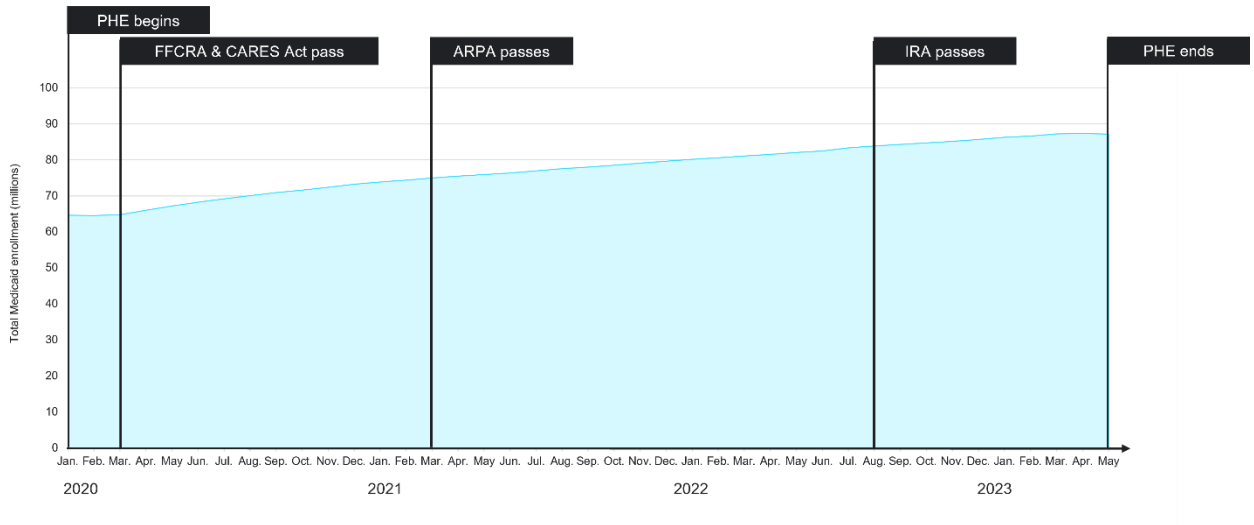
Figure 2. Seasonal influenza vaccination rates and annual Medicaid coverage disruption and loss rates among adults in expansion vs. non-expansion states, 2011-2016[39,40]



Medicaid continuous enrollment during the COVID-19 pandemic

On January 31, 2020, the US Department of Health and Human Services declared the COVID-19 pandemic a PHE.[41] Recognizing the importance of maintaining access to healthcare coverage during the PHE, several laws were enacted that enabled continuous coverage for Medicaid enrollees regardless of changes to income and whether an individual still met eligibility requirements.

Figure 3. COVID-19 pandemic policy milestones, Medicaid enrollment, and Medicaid adult vaccinations, Mar. 2020-May 2023[42,43,44]



ARPA: American Rescue Plan Act; CARES: Coronavirus Aid, Relief, and Economic Security

The FFCRA, enacted in March 2020, temporarily increased the FMAP for Medicaid by 6.2 percentage points for states that agreed not to disenroll beneficiaries and ensured Medicaid coverage for all COVID-19-related services, including vaccination, without cost sharing.[45] Notably, this law restricted states from redetermining Medicaid eligibility during the PHE. All states and DC agreed to the pause in disenrollments in exchange for the enhanced FMAP.

The CARES Act, also enacted in March 2020, created a $150 billion Coronavirus Relief Fund to support state and local public health response, Medicaid programs, and other activities.[46] While this law primarily focused on economic recovery, it also authorized the initial funding for “Operation Warp Speed,” which aimed to enhance and speed development of COVID-19 vaccines.[47]

ARPA, enacted in March 2021, aimed to address the continuing impact of COVID-19 by incentivizing Medicaid expansion with an additional temporary increase in the FMAP for states that had not yet expanded Medicaid by five percentage points for the first eight calendar quarters upon implementing expansion.[48] ARPA also authorized $7.5 billion to support COVID-19 vaccine distribution and $47 billion to support disease control efforts like testing and contact tracing.[49]

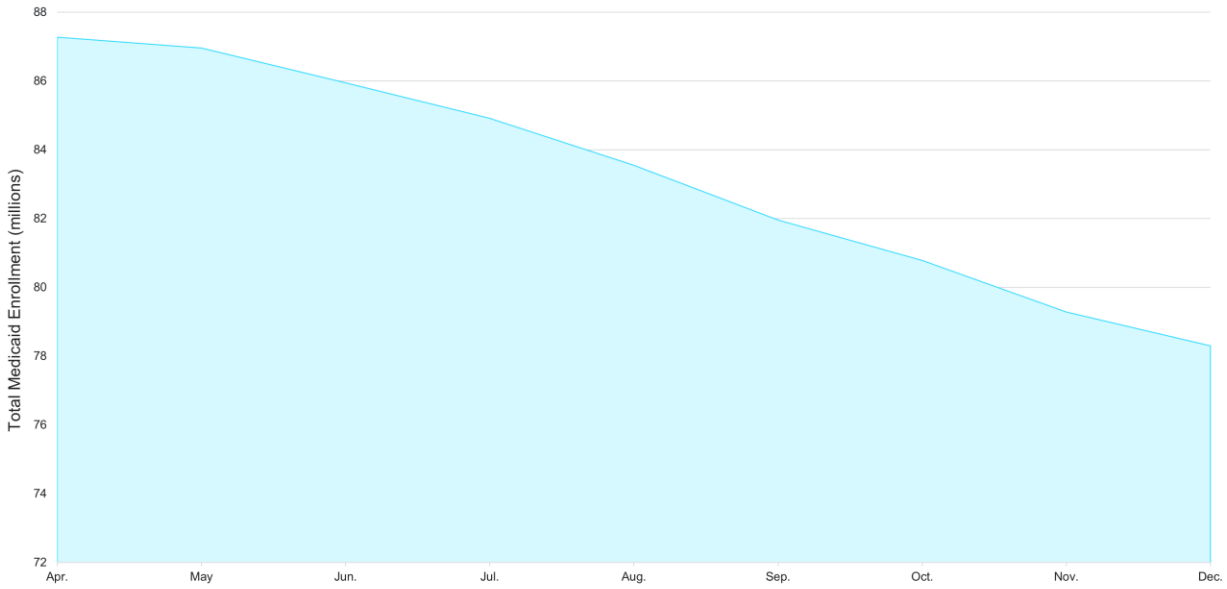
Impact of pandemic-era Medicaid policies on vaccine access and uptake

By incentivizing states to pause eligibility redeterminations and expand Medicaid eligibility, the FFCRA and CARES Act solidified healthcare coverage protections for Medicaid enrollees through continuous coverage during the PHE.[50] As a result, Medicaid and CHIP enrollment grew by 21.2 million enrollees (29.8%) from February to December 2022, and four additional states implemented Medicaid expansion (ID, NE, MO, UT).[51]

The end of the COVID-19 PHE on May 11, 2023 led to the expiration of several policies, including the phasing out of the enhanced federal matching rate through the end of 2023.[52] Medicaid continuous enrollment requirements had expired just over one month prior, on March 31.[53] On April 1, CMS allowed states to resume Medicaid coverage terminations, and five states did so on day 1: AR, AZ, ID, NH, and SD.[54] An additional 14 states began coverage terminations on May 1.[55]

By the end of 2023, total Medicaid enrollment declined by nearly nine million individuals.[56] Many individuals who lost their Medicaid coverage were not aware that states were allowed to conduct coverage redeterminations, nor that they had to provide specific information to remain enrolled; as a result, many had not pursued alternative coverage options and had no healthcare coverage.[57] Subsequently, these individuals would likely be required to pay OOP for routinely recommended vaccinations.

Figure 4. Total Medicaid enrollment, April-December 2023[58]



For those who retained Medicaid coverage, the IRA enacted additional provisions to support vaccine access. Specifically, the law required all Medicaid programs, regardless of expansion status, to cover ACIP recommended vaccines without cost sharing beginning October 1, 2023.[59] This meant that adults could obtain vaccinations without OOP costs, even if covered under traditional Medicaid programs that had previously been allowed to impose cost sharing for vaccines.

Despite IRA protections, individuals who lost Medicaid coverage following the end of continuous enrollment also encountered barriers to accessing vaccines. However, states differed in how and when they chose to unwind continuous coverage and conduct redeterminations, resulting in varying impacts to healthcare coverage and vaccination rates.

Case studies

Three states—CA, MD, and MN—illustrate the programs and policies that facilitated unwinding at the end of the COVID-19 PHE. All three states implemented Medicaid expansion at the earliest possible date (January 1, 2014) and followed federal requirements to maintain continuous Medicaid enrollment during the PHE. From April to December 2023, Medicaid program enrollment in these states declined between 3.5-3.9% (Table 2). This is low compared to other states; for example, in FL, Medicaid enrollment declined approximately 20%.[60] This suggests that the programs implemented in these states were largely successful in helping people maintain coverage and, therefore, maintain vaccine access without cost sharing.

Table 2. CA, MD, and MN Medicaid program enrollment (2019-2023) and enrollment decline from April-December 2023[61]

State	Total Medicaid enrollment, December					Enrollment decline (%), April-December 2023
	2019	2020	2021	2022	2023	
California	10.3M	11.2M	11.9M	12.8M	12.5M	510,663 (3.9%)
Maryland	1.2M	1.3M	1.4M	1.5M	1.5M	54,400 (3.5%)
Minnesota	1.0M	1.2M	1.3M	1.4M	1.4M	50,085 (3.7%)

California

CA implemented a phased unwinding approach that began on April 1, 2023, with the first disenrollments effective July 1, 2023.[62] Prior to conducting eligibility redeterminations, the Department of Health Care Services (DHCS) created the Coverage Ambassadors program. This program provides resources for any interested resident to share Medicaid information with other residents in an effort to reach broader

populations and marginalized communities; this includes explaining what residents need to do to maintain their coverage.[63]

The state also expanded access to re-enrollment resources, including help with paperwork and guidance on finding alternative coverage (e.g., private insurance coverage via the state marketplace Covered California). Additionally, the state implemented several Medicaid enhancements, including partnering with the United States Digital Service to automate income validation.[64] Also known as *ex parte* renewal, this process reduced the need for individuals to submit documentation and resulted in a decline in Medi-Cal disenrollments from 19-21% at the beginning of the state's unwinding to 9% in December 2023.[65]

To facilitate transitioning disenrolled individuals to new coverage via Covered California, the DHCS and Covered California collaborated to implement automatic plan selection for those disenrolled from Medicaid.[66] By the end of 2023, nearly 250,000 CA residents newly enrolled in health insurance through Covered California, a 20% increase from the previous year.[67] While 6.4% of CA residents were uninsured in 2023, it is unclear what proportion of newly enrolled and uninsured individuals may be those disenrolled from Medicaid.[68]

Maryland

MD was recognized by KFF as one of the top ten states for maintaining Medicaid enrollment during the unwinding process.[69] The state took advantage of federal flexibility policies, like using *ex parte* renewals.[70] MD implemented a process to determine Medicaid eligibility for 226,000 people via Supplemental Nutrition Assistance Program enrollment, contributing to one of the highest automatic enrollment rates in the US.[71] The state also implemented several communication partnerships, such as a collaboration between CareFirst Community Health Plan of Maryland and Fabric Health, a non-profit organization aimed at "improving the lives of busy families," to make bilingual care coordinators accessible via community laundromats.[72] These care coordinators, which were prioritized for zip codes with significant health disparities, were charged with helping families submit Medicaid redetermination documentation and learn about additional benefits and services.[73]

Like in CA, people deemed ineligible for Medicaid were automatically referred to the state's health insurance marketplace, the Maryland Health Connection, to sign up for a low-cost plan.[74] In 2023, just over 182,000 MD residents newly enrolled in a health plan through the Maryland Health Connection, a 3% increase from 2022; nearly 6,300 people enrolled via the "Medicaid to Private Plan Enrollment Program."[75] However, the rate of uninsured people aged 0-64 years increased from 7% in 2022 to 7.5% in 2023.[76]

Minnesota

To mitigate the potential impact of conducting eligibility redeterminations beginning April 1, 2023, MN implemented a strategy to maintain coverage for eligible people and facilitate transitions to other health insurance coverage for people deemed ineligible for Medicaid.[77] For example, the state increased the use of *ex parte* renewal, contributing to a 6% decrease in disenrollment rates.[78,79]

For those who were determined ineligible for Medicaid, the Department of Human Services coordinated with MNsure, the state's individual insurance marketplace, to facilitate enrollment in private insurance coverage.[80] Part of this strategy included extending the special enrollment period (SEP) for individuals disenrolled from Medicaid. There were nearly 160,000 enrollments for Qualified Health Plans in 2023, though it is unclear how many of those were individuals or families transitioning from Medicaid coverage.[81] Further, 3.8% of Minnesota's residents were uninsured in 2023, most of whom were uninsured for the full calendar year, suggesting a limited number of individuals disenrolled from Medicaid remained uninsured.[82]

Future considerations

The PHE expiration and the return to churn may be exacerbated by policies proposed at the federal and state levels. For example, the administration is also considering changes to individual commercial insurance enrollment that could limit the ability of individuals disenrolled from Medicaid to transfer to private insurance. CMS issued its 2025 Marketplace Integrity and Affordability Proposed Rule, in which the agency proposed in part to:[83]

- Shorten the open enrollment period to end on December 15 (vs. January 15)
- Mandate pre-enrollment verification for SEP eligibility; eliminate monthly SEP eligibility for people with projected household incomes at or below 150% FPL
- Require enrollees receiving Advanced Premium Tax Credits to annually confirm eligibility (vs. automatic re-enrollment), and charge these enrollees a $5 per month premium until eligibility confirmation is received

In response to the federal Medicaid program cuts anticipated in the OBBBA, some states aimed to strengthen their Medicaid programs during 2025 legislative sessions:

- **California:** Legislators agreed to expand Medi-Cal eligibility to all low-income adults regardless of immigration status.[84] Governor Gavin Newsom later signed legislation to close a $2.8 billion Medicaid funding gap on April 14, 2025, to ensure this expanded coverage remained in place through June 2025.[85]
- **Minnesota:** Legislators introduced two bills: HF 1005, which would require the state's Medicaid program to increase provider reimbursement rates; and HF 2591, which would raise taxes on millionaires in the state to offset potential cuts to federal Medicaid funding.[86,87]

Mandatory eligibility redetermination, overarching reductions in Medicaid enrollment, and Medicaid program and financing changes included in the OBBBA could together result in significant coverage disruptions and increased numbers of uninsured individuals, potentially driving down vaccination rates.[88] Given uncertainty about the future of federal Medicaid policy and funding, the lag in CMS data availability, and variation in how states collect and publish vaccination data, it is also unclear how states may continue to pursue strengthening their respective programs and how the federal landscape could drive outcomes to affect adult access to vaccines. Further, if finalized, potential changes to marketplace

enrollment could create barriers to obtaining individual commercial coverage as an alternative, which could help individuals maintain vaccine access without cost sharing.

Historically, policies supporting expansion of Medicaid coverage have correlated with increases in vaccine uptake.[89] Novel solutions to safeguard healthcare coverage and vaccine access within the current policy landscape may be considered by a broad range of stakeholders; however, the availability of timely vaccination data remains variable. Given the heterogeneity of Medicaid programs, states may minimize the impact of churning by prioritizing *ex parte* renewals. Additionally, states may leverage opportunities to standardize and aggregate Medicaid data collection and reporting, harmonizing with Immunization Information Systems and Health Information Exchanges. Finally, qualitative assessments of immunization experiences following disenrollment could also elucidate the patient perspective and provide further evidence to support mitigating barriers and identifying solutions to improve access.

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