

Migration Patterns for Medicaid Enrollees, 2005-2007

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Although Medicaid is a federal program, it is administered primarily by the states. Since the program's inception, national reporting on enrollment has consisted of aggregated state reports. Enrollees move from state to state, but their migration patterns have remained largely unknown. Accordingly, there are concerns about the possibility of enrollment gaps, lack of health insurance coverage, breaks in continuity of care, unmet need and risks to health status, and increased cost to the overall health care system in terms of uncompensated care and the use of higher cost emergency room services because of enrollment gaps. There is also concern about the extent to which people enrolled in more than one state are double counted. This issue brief presents analyses using data from a special source—Medicaid enrollment records that have been unduplicated and linked across states and over time—to examine the migration of Medicaid enrollees across states from 2005 through 2007. Among all enrollees over this period, 3.7 percent moved to another state at least once, and most moved only once. Overall, 72.2 percent of moves did not result in an enrollment gap, whereas 8.2 percent of moves resulted in gaps of fewer than three months, and 11.4 percent of moves resulted in gaps of more than six months. These findings provide a context for further examining the consequences of enrollee moves on their health and on program expenditures. The consequences of enrollee moves related to enrollment gaps will become increasingly important as the Medicaid population grows under the provisions of the Affordable Care Act.

Background

Throughout the history of Medicaid, little has been known about cross-state enrollee patterns for three primary reasons: Medicaid is administered by the states; national statistics are aggregates of state statistics; and enrollee identifiers are typically unique only within each state. The state-based administration of Medicaid has raised concerns about enrollment gaps

About This Series

The MAX Medicaid policy issue brief series highlights the essential role MAX data can play in analyzing the Medicaid program. MAX is a set of annual, person-level data files on Medicaid eligibility, service utilization, and payments that are derived from state reporting of Medicaid eligibility and claims data into the Medicaid Statistical Information System (MSIS). MAX is an enhanced, research-friendly version of MSIS that includes final adjudicated claims based on the date of service, and data that have undergone additional quality checks and corrections. CMS produces MAX specifically for research purposes. For more information about MAX, please visit: http://www.cms.gov/MedicaidDataSourcesGenInfo/07_MAXGeneralInformation.asp.

when enrollees move, the absence of coverage during the gaps (Czajka 1999; Sommers 2008), continuity of care, unmet need and risks to enrollee health status, and increased cost to the overall health care system in terms of uncompensated care and the use of higher cost emergency room services because of enrollment gaps.

Other concerns center on the extent to which individuals enrolled in more than one state are double counted. An analysis of the underestimate of Medicaid enrollment in the Current Population Survey, conducted as part of the Medicaid Undercount project (Call et al. 2001/2002; Davern et al. 2009), highlighted the importance of unduplicating enrollee records across states. Other researchers have noted additional issues associated with using Medicaid administrative data as the “gold standard” for both counting enrollees and estimating the size of the uninsured population (Dubay et al. 2007).

While moves occur within and across states, the analyses described here examined only cross-state moves.

Data

States must submit person-level data on Medicaid enrollment, services, and payments to the Centers for Medicare & Medicaid Services (CMS) through the Medicaid Statistical Information System (CMS 2012). Because the MSIS administrative data cannot easily be used for research, CMS developed MAX data, person-level enrollment and event-level services data for each Medicaid enrollee and each Medicaid expansion Children's Health Insurance Program (CHIP) enrollee. MAX data are annual state-specific data files in which MSIS records are aggregated by calendar year. Interim MSIS transactions are adjusted to produce final-action records.

A substantial number of other edits and validation activities enhance the usefulness and quality of MAX data. Although the data are widely used for research and policy analysis on many topics, their utility is limited for certain types of research because eligibility records have not been linked for people who are enrolled in more than one state. To address this limitation, CMS contracted with Mathematica Policy Research to design and construct unduplicated research files that appropriately reconcile duplicate Medicaid enrollment records in MAX 2005, 2006, and 2007, creating an unduplicated research file that contains one record for each enrolled person (Czajka et al. 2010; Czajka and Verghese 2011). In the analyses described here, we used the unduplicated data linked across states for 2005 through 2007.

Findings

The findings cover two major areas: (1) at the national level, the number of enrollees by number of moves, the number of states to which enrollees moved, the number of moves associated with enrollment gaps of different lengths, and the average length of enrollment episodes; and (2) at the state-level, enrollee migration, by state, and moves between pairs of states.

National-Level Findings

Enrollees Who Moved. Of nearly 76 million Medicaid enrollees in the 50 states and the District of Columbia from 2005 through 2007, over 73 million (96.3 percent) did not move from one state to another during the study period, leaving 2.8 million (3.7 percent) who moved at least once and obtained Medicaid coverage in more than one state (Table 1). By Medicaid Basis of Eligibility (BOE), other children (that is, children other than disabled and foster care children) older than 6, other children age 1 to 6, and adults represented the greatest number of people who moved, in part because these groups had the most enrollees. However, the highest percentage of enrollees who moved were children age 1 to 6 (5.5 percent) and foster care children (5.3 percent). At just 2.0 percent, aged enrollees accounted for the lowest percentage of movers.

Table 1. Number and Percent of Medicaid Enrollees Who Moved and Did Not Move, by Eligibility Group, 2005–2007

Medicaid Eligibility Group	Number of Enrollees	Number of Enrollees Who Did Not Move	Percent of Enrollees Who Did Not Move	Number of Enrollees Who Moved	Percent of Enrollees Who Moved
Aged	6,930,227	6,794,393	98.0	135,834	2.0
Disabled	10,181,053	9,724,575	95.5	456,478	4.5
Adult	22,306,979	21,654,911	97.1	652,068	2.9
Foster care children	1,160,948	1,099,513	94.7	61,435	5.3
Other children under age 1	3,531,965	3,443,899	97.5	88,066	2.5
Other children age 1 to 6	12,795,395	12,093,524	94.5	701,871	5.5
Other children over age 6	18,692,953	17,958,249	96.1	734,704	3.9
All enrollees ^{a,b}	75,960,337	73,129,879	96.3	2,830,458	3.7

Source: Mathematica's analysis of unduplicated MAX enrollment records, 2005–2007.

^a Includes 360,817 child enrollees of unknown age.

^b Excludes 364,540 enrollees for whom it was not possible to determine whether a move occurred or the origin and destination states of a move. It also excludes 3 enrollees with no BOE.

Number of Moves and Number of States. Only 3.7 percent of enrollees moved at least once, 2.9 percent moved once, 0.7 percent moved twice, and 0.1 percent moved three or more times (data not shown, see Baugh and Verghese 2012). Among enrollees who moved at least once, the vast majority (3.5 of 3.7 percent) moved between only two states one or more times (data not shown, see Baugh and Verghese 2012). Of all enrollees who moved, 77.1 percent moved only once during the study period, varying by BOE group from 73.2 percent (other children age 1 to 6) to 87.7 percent (aged enrollees) (Table 2). Those who moved twice and those who moved three or more times represented 19.1 percent and 3.8 percent, respectively, of all enrollees who moved. Among enrollees who moved twice, 80.2 percent moved to a new state and then back to the original state (data not shown, see Baugh and Verghese 2012). For enrollees who moved three or more times, slightly less than half (44.3 percent)

were enrolled in only two states, with the remainder demonstrating a variety of moving patterns involving more than two states (data not shown, see Baugh and Verghese 2012).

Moves Associated with Enrollment Gaps. For all enrollees, 72.2 percent of moves did not result in an enrollment gap (Table 3). The percent of moves resulting in gaps in enrollment of fewer than three months (8.2 percent) was fairly consistent as the number of moves increased, ranging from 7.9 to 8.8 percent. The share of all enrollees with gaps of more than six months was 11.4 percent, but it declined monotonically as the number of moves increased—14.4 percent for one move versus 1.2 percent for five or more moves. We observed the same decreasing pattern in the percent of moves resulting in an enrollment gap as the number of moves increased for all BOE groups with gaps of more than six months (data not shown, see Baugh and Verghese 2012).

Table 2. Number and Percent of Medicaid Enrollees Who Moved, by BOE Group and the Number of Moves, 2005-2007

BOE Group	Number of Enrollees Who Moved	Number of Moves		
		One	Two	Three or More
Aged	135,834	87.7	10.8	1.5
Disabled	456,478	77.1	18.6	4.3
Adult	652,068	78.0	18.6	3.4
Foster care children	61,435	80.0	16.8	3.5
Other children under age 1	88,066	84.0	13.8	2.3
Other children age 1 to 6	701,871	73.2	22.2	4.7
Other children over age 6	734,704	77.1	19.2	3.7
All enrollees	2,830,458	77.1	19.1	3.8

Source: Mathematica's analysis of unduplicated MAX enrollment records, 2005-2007.
Note: An enrollee can move back to a state in which he or she was previously enrolled.

Table 3. Number of All Medicaid Enrollees, Number of Moves, and Percent of Moves with Gaps in Enrollment, 2005-2007

	Number of Enrollees ^a	Number of Moves	Percent of Moves with No Gap	Percent of Moves with a Gap of Fewer Than 3 Months ^b	Percent of Moves with a Gap of 3 to 6 Months ^b	Percent of Moves with a Gap of More Than 6 Months ^b
All enrollees	75,960,337					
No moves	73,129,879					
One move	2,182,791	2,182,791	69.3	7.9	8.5	14.4
Two moves	539,678	1,079,356	75.3	8.8	7.9	8.0
Three moves	81,650	244,950	79.8	8.7	6.9	4.6
Four moves	19,462	77,848	83.2	8.6	5.7	2.5
Five or more moves	6,877	37,647	86.5	8.3	4.1	1.2
One or more moves	2,830,458	3,622,592	72.2	8.2	8.1	11.4

Source: Mathematica's analysis of unduplicated MAX enrollment records, 2005-2007.

^a These numbers include 360,817 child enrollees of unknown age.

^b A gap in enrollment of fewer than three months may reflect the time required by the new state to determine eligibility, whereas a longer gap may mean that the person was not granted eligibility in the new state.

State-Level Findings

Migration by State. Between 2005 and 2007, five states registered out-migration of more than 150,000 enrollees: California, Florida, Texas, New York, and Louisiana (Table 4). Given that four of these states had the highest number of Medicaid enrollees among all states, it is reasonable to expect large numbers of migrants. Louisiana, however, ranked 17th in the size of its enrolled population over the three-year period, so it is likely that the large number of out-migrants from the state was a result of Hurricane Katrina (August 2005). In three states, the number of in-migrants exceeded 150,000: Texas, Florida, and California (Table 4). Four states realized a net increase of more than 20,000 migrants: Texas (+70,813), Georgia (+45,536), North Carolina (+43,303), and Arizona (+20,175) (Table 4). Another four states experienced a net decrease of more than 20,000 migrants: California (-79,295), Louisiana (-75,630), New York (-74,049), and Illinois (-25,519) (Table 4). States with the highest Medicaid in-migration rates (over 7.0 percent) were all mid-western or mountain states: Nevada (11.9 percent), Wyoming (9.9 percent), North Dakota (8.4 percent), Montana (7.9 percent), South Dakota (7.8 percent), Idaho (7.8 percent), and Kansas (7.2 percent).

In general, Medicaid migration patterns in the analysis mirrored the patterns observed for the general population in that states with higher Medicaid in-migration rates had higher general population in-migration rates. Noteworthy outlier states with Medicaid in-migration rates of more than 4 percent higher than general population in-migration rates were Nevada (6.5 percent), Wyoming (4.5 percent), North Dakota (4.6 percent), and South Dakota (4.2 percent) (data not shown, see Baugh and Verghese 2012). However, Medicaid in-migration rates were lower than those in the general population for five states: Alaska, California, the District of Columbia, Hawaii, and Vermont (data not shown, see Baugh and Verghese 2012).

Enrollee Moves for State Pairs. We observed that, by a wide margin, the largest number of enrollees (68,964) moved from Louisiana to Texas, undoubtedly in response to Hurricane Katrina (Table 5). This number was two-thirds higher than the number of enrollees who moved from California to Arizona, the pair of states with the next highest number of movers. Even though the number of enrollees moving from Texas to Louisiana did not rank as high as the number moving in the opposite direction, these enrollees represented the sixth-highest number of movers between a pair of states. The pairs with the highest rankings were, not surprisingly, often neighboring states. For

several pairs, the number of enrollees who moved was high in both directions. In other instances, a substantial number of enrollees moved in one direction but not in the other. For most state pairs, the share of moves resulting in an enrollment gap was below 35 percent, but noteworthy exceptions were the shares of moves from Georgia to Alabama (43.5 percent), Texas to Louisiana (42.5 percent), Texas to Florida (37.3 percent), and Georgia to Florida (35.9 percent) (data not shown, see Baugh and Verghese 2012).

Limitations

The findings presented above should be interpreted cautiously because the analyses have several important limitations, as discussed below.

There is nothing to prevent individuals from simultaneously enrolling in Medicaid in more than one state because states do not necessarily consult with one another before granting eligibility. When an enrollee moves, the original state may not know of the move and may not terminate eligibility. We excluded 364,540 people from the study who enrolled in more than one state at the same time with the same eligibility-episode starting date in at least two states because we were unable to verify that a move occurred or to determine the origin and destination states. Migration rates would have been higher had we included these enrollees. We did include 306,356 enrollees with a state-specific eligibility episode for one state that occurred completely within an episode for another state, but we needed to develop consistent counting rules for them.¹

In addition, the data may not show an enrollment gap when a person does not re-enroll in the destination state at the time of the move. The individual may not know that he or she is still enrolled in the original state and may behave as though he or she is no longer enrolled. We have no information about enrollees who moved but did not re-enroll until after 2007. For these reasons, the observed migration patterns may not fully reflect the underlying migration patterns for the study years. We have no data on the reasons for moves or enrollment gaps, which forces us to speculate about possible reasons for a move (e.g., Hurricane Katrina or the “snow bird” phenomenon). Beyond Medicare coverage, the data provide only limited information on other health insurance coverage and changes in coverage over time. Medicaid enrollee migration patterns for the study years may differ from the patterns observed for other years and may not apply to the Medicaid population after the Affordable Care Act (ACA) is implemented because the composition of the enrollee population will change.

Table 4. Number of Medicaid Enrollees Who Moved and Number of Moves by State, 2005–2007

State	Medicaid		Number of Enrollees Who Moved		
	Total Unduplicated Number of Enrollees ^a	In-Migration Rate (%) ^{a,b}	Out	In	Net
Alabama	1,142,114	4.0	53,059	57,385	4,326
Alaska	164,407	5.5	10,777	10,755	-22
Arizona	1,948,818	5.1	102,733	122,908	20,175
Arkansas	896,002	5.8	60,626	67,223	6,597
California	14,541,148	1.2	295,892	216,597	-79,295
Colorado	733,900	5.7	49,927	53,519	3,592
Connecticut	655,239	4.0	31,308	31,370	62
Delaware	228,173	6.0	13,571	16,656	3,085
District of Columbia	190,362	5.2	15,227	11,889	-3,338
Florida	3,824,219	4.8	249,064	232,782	-16,282
Georgia	2,292,036	6.1	132,722	178,258	45,536
Hawaii	284,996	2.9	13,943	10,521	-3,422
Idaho	284,358	7.8	25,014	27,983	2,969
Illinois	2,994,028	3.3	148,749	123,230	-25,519
Indiana	1,305,847	5.6	80,558	91,859	11,301
Iowa	591,102	6.3	40,581	47,826	7,245
Kansas	456,212	7.2	39,630	41,772	2,142
Kentucky	1,064,129	5.1	56,975	68,751	11,776
Louisiana	1,330,061	5.0	153,766	78,136	-75,630
Maine	414,079	3.4	14,785	16,968	2,183
Maryland	1,050,884	3.8	57,097	49,334	-7,763
Massachusetts	1,553,054	2.4	53,252	43,143	-10,109
Michigan	2,372,375	2.8	102,277	84,480	-17,797
Minnesota	1,022,459	4.7	53,735	61,662	7,927
Mississippi	928,157	4.2	56,049	47,599	-8,450
Missouri	1,416,442	4.8	86,968	86,666	-302
Montana	145,161	7.9	14,061	14,925	864
Nebraska	326,742	6.8	27,634	28,955	1,321
Nevada	359,504	11.9	46,849	56,545	9,696
New Hampshire	178,598	6.5	13,160	14,130	970
New Jersey	1,334,686	3.6	68,545	57,363	-11,182
New Mexico	639,980	5.5	42,571	44,351	1,780
New York	6,208,059	1.7	195,870	121,821	-74,049
North Carolina	2,106,808	5.7	102,847	146,150	43,303
North Dakota	95,760	8.4	9,717	10,835	1,118
Ohio	2,624,193	3.5	112,449	113,462	1,013
Oklahoma	944,323	6.1	59,865	73,965	14,100
Oregon	688,411	6.8	50,331	59,052	8,721
Pennsylvania	2,553,561	3.6	99,032	111,253	12,221
Rhode Island	257,993	3.9	15,638	12,204	-3,434
South Carolina	1,182,693	4.0	57,872	58,106	234
South Dakota	157,109	7.8	14,385	15,775	1,390
Tennessee	1,809,765	4.5	99,567	105,342	5,775
Texas	5,566,667	4.1	215,166	285,979	70,813
Utah	430,411	6.4	27,484	33,870	6,386
Vermont	197,077	3.7	8,460	8,890	430
Virginia	1,118,501	5.4	67,277	75,186	7,909
Washington	1,506,780	5.1	81,665	94,883	13,218
West Virginia	474,798	5.8	33,248	35,165	1,917
Wisconsin	1,267,704	3.9	55,002	61,016	6,014
Wyoming	100,455	9.9	11,617	13,143	1,526

Source: Mathematica's analysis of unduplicated MAX enrollment records, 2005-2007. Note: The same enrollee can move from more than one state. Across all states, the number of enrollees moving in and out will not necessarily net to a value of 0. See the technical appendix of the full report for details.

^a These counts are based on the last recorded state of residence and the last recorded move for each enrollee during the study period so that each enrollee is counted only once for this comparison.

^b Excluding 364,540 people who were enrolled in more than one state with the same starting month for at least two state-specific enrollment episodes. These individuals were excluded because it was not possible to determine if a move actually occurred or to ascertain the direction of a move from one state to another. The percentages would have been somewhat higher had these enrollees been included.

Table 5. Number of Moves and Gaps in Enrollment After the Move, by Pairs of States with More Than 20,000 Medicaid Enrollees Who Moved, 2005–2007

Origin State	Destination State	Number of Enrollees Who Moved	Percent of Moves with an Enrollment Gap		
			Gap of Fewer Than 3 Months ^a	Gap of 3 to 6 Months ^a	Gap of More Than 6 Months ^a
Louisiana	Texas	68,964	2.7	3.5	3.9
California	Arizona	41,370	8.1	8.8	13.8
New York	Florida	37,261	7.6	8.3	13.2
Florida	Georgia	34,674	7.2	8.0	11.4
California	Texas	32,883	9.1	10.3	14.4
Texas	Louisiana	30,350	8.6	13.3	20.6
New York	Pennsylvania	27,838	6.8	7.7	12.7
California	Nevada	26,845	9.9	10.3	14.2
Arizona	California	25,957	9.6	9.1	11.5
California	Washington	24,904	8.0	7.1	9.8
Florida	New York	24,720	8.9	9.8	15.0
Georgia	Florida	22,840	10.6	10.8	14.5
Illinois	Indiana	22,473	4.4	4.3	6.3

Source: Mathematica’s analysis of unduplicated MAX enrollment records, 2005–2007.

^a A gap in enrollment of fewer than three months may reflect the time required by the new state to determine eligibility, whereas a longer gap may mean that the person was not granted eligibility in the new state.

Implications

The national data count enrollees for each state in which they were enrolled, thus over-counting the national enrollment. However, the magnitude of the over-count is relatively small, with only 3.7 percent enrolled in more than one state (Table 1). That said, it is still appropriate to adjust the national enrollee counts accordingly, thereby improving both national estimates of Medicaid enrollees and estimates of the uninsured population.

For movers with enrollment gaps, 27.8 percent (Table 3, 72.2 percent did not have gaps), the percent of moves in which the gap was shorter than three months remained constant as the number of moves increased. In contrast, the percent of moves associated with gaps longer than six months decreased as the number of moves increased from one move (14.4 percent) to five or more moves (1.2 percent) (Table 3). This pattern persisted for all BOE groups (data not shown, see Baugh and Verghese 2012). However, various factors may account for this decrease.² First, the socioeconomic characteristics of enrollees with more moves (e.g., lower income) may have differed from the characteristics of those with fewer moves, increasing the likelihood that the former would qualify for Medicaid in a new state. Second, enrollees who moved more times may have gained a better understanding of eligibility policies, allowing them to apply more easily for Medicaid in a new state. We hope that future research will provide further insight into this finding.

Among all enrollees who moved, the average length of eligibility episodes remained relatively constant as the number of moves increased (data not shown, see Baugh and Verghese 2012). This finding indicates that most moves are not associated with enrollment gaps and that enrollees do not appear to become “weary” of the Medicaid application process in new states as the number of moves increases. For children under age 1 who moved, the average length of an eligibility episode increased twofold, from 7.4 months to 15.3 months as the number of moves increased (data not shown, see Baugh and Verghese 2012). The reasons for the increase are unclear, but underlying differences in family characteristics and income may play a role. The observed decrease in the average length of an eligibility episode for disabled and foster care child enrollees as the number of moves increased is cause for concern (data not shown, see Baugh and Verghese 2012).

At the state level, Medicaid in-migration rates ranged from 11.9 percent (Nevada) to 1.2 percent (California). Typically, state Medicaid in-migration rates were higher than in-migration rates for the general population. As mentioned, Hurricane Katrina (August 2005) likely contributed to high net out-migration from Louisiana, but positive net in-migration for children under age 1 in Louisiana was one of the highest observed numbers for any state (data not shown, see Baugh and Verghese 2012). In-migration rates for Texas and Georgia were high for

most BOE groups (data not shown, see Baugh and Verghese 2012). It is important to understand these patterns because large numbers of in-migrants may place a heavy burden on Medicaid eligibility operations and health care delivery systems.

Many moves occurred between neighboring states. Using more detailed, state-specific definitions of eligibility groups as well as age and other data, further research could provide a sharper picture of the characteristics of those who move. As noted above in the section on Enrollee Moves for State Pairs, the percent of moves associated with gaps was below 35 percent for most state pairs. However, the rate was especially high for moves from Texas to Louisiana (42.5 percent) and Georgia to Alabama (43.5 percent), possibly indicating unusual stress on eligibility operations in Louisiana and Alabama after Hurricane Katrina as evacuees returned to their home state.

Future research should provide more detail on the migration of Medicaid enrollees, the reasons for it, and how to reduce the frequency and duration of enrollment gaps associated with it. This issue will become increasingly important as Medicaid expands to over 16 million new people and as program costs rise under ACA provisions.

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Endnotes

- ¹ A technical appendix to the full report provides additional details.
- ² This finding could be an artifact of state eligibility policies that do not necessarily terminate eligibility for people who move. See the Limitations section.

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