



Shrinking the Medicaid Cliff: How Congress Can Prevent Health Equity Disaster by Protecting Eligible Families' Health Care

Introduction and Summary

When Health and Human Services (HHS) Secretary Xavier Becerra formally declares an end to the Public Health Emergency (PHE), Medicaid programs will be allowed to terminate beneficiaries' coverage for the first time since February 2020. If Medicaid operates as it did in the past, a major civil rights and health equity disaster will result. According to the HHS Assistant Secretary for Planning and Evaluation (ASPE), 15 million people will lose Medicaid if the program returns to typical pre-pandemic operations.¹ To place that finding in context, the number of people expected to lose Medicaid is (Figure 1):

- More than seven times the size of history's largest one-year drop in Medicaid coverage ever recorded, when the number of Medicaid beneficiaries fell by 2 million in 2018 and again in 2019.²
- More than six times the number of people who are denied coverage because they fall into the "Medicaid coverage gap" (2.2 million).³

Once Medicaid terminations resume, the majority of those projected to lose coverage will be people of color, according to ASPE, including 4.6 million Latinos,⁴ 2.2 million African Americans, and nearly a million Asian Americans and Pacific Islanders (Figure 2). Their losses will be quite different from those experienced by non-Hispanic whites, only 17% of whom will be dropped from Medicaid despite remaining eligible. By contrast, 40% of African American beneficiaries, 51% of AAPI beneficiaries, and a staggering 64% of Latino beneficiaries projected to lose Medicaid will remain eligible but will be terminated because of failure to meet state administrative requirements (Figure 3).

These troubling findings are consistent with earlier research showing that, if terminations take place at pre-pandemic levels, at least 12% of all children of color who live in the United States will likely lose Medicaid, including 13% of all African American children, 12% of all Latino children, 12% of all American Indian/Alaska Native children, and 10% of all Native Hawaiian and Pacific Islander children (Figure 4).⁵ By contrast, Medicaid terminations will affect 6% of all children who are non-Hispanic whites—tragically many, but literally half the burden born by children of color.

People who lose Medicaid frequently cannot obtain the health care they need, causing chronic conditions like cancer to go undetected or grow more severe, often with grim consequences.⁶ Struggling families would thus suffer a terrible toll if the Medicaid losses projected by ASPE take place.

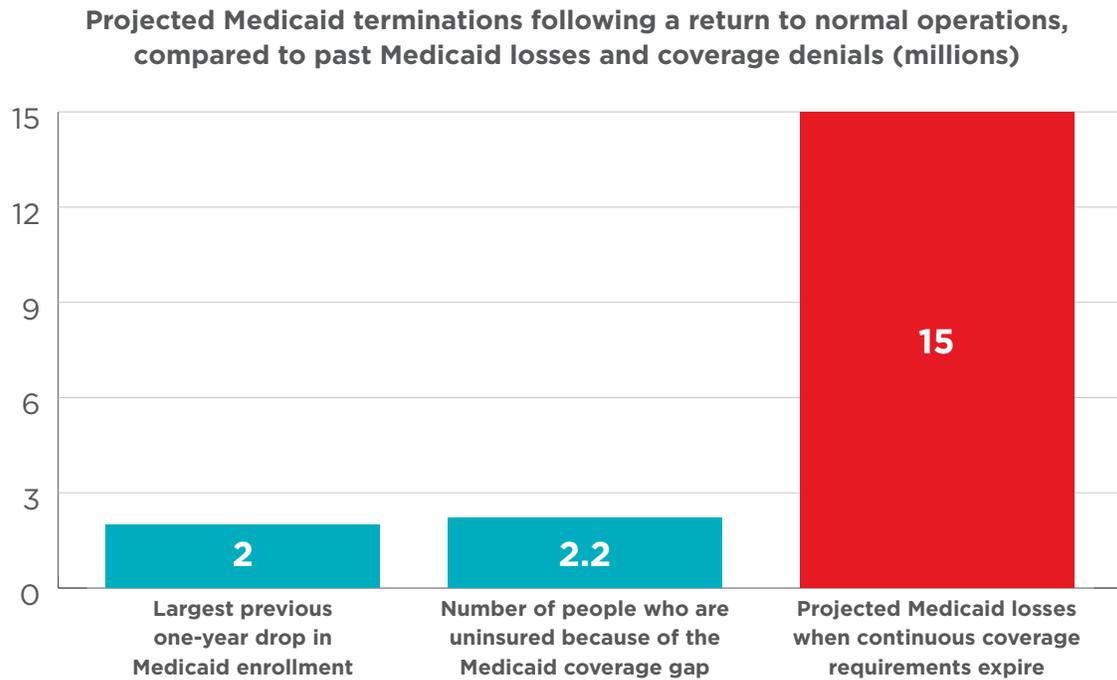
Those losses would nullify many of the coverage gains federal policymakers have achieved in recent years. Since 2020, the number of uninsured fell by 5.2 million.⁷ These historic gains would be offset or erased by the end of President Biden's first term if 15 million people lose Medicaid, as projected by ASPE (Figure 5).

To mitigate this major civil rights disaster, Medicaid must operate differently than in the past. The Administration and Congress have already done significant work to limit health care losses. Nonetheless, three changes to the Medicaid statute are needed to create clear expectations for state performance and to give HHS authority to protect families:

1. A state's administrative terminations should be placed on hold if the state does not achieve target outcomes or if HHS finds state policy is causing preventable terminations of eligible people.
2. The outcome standards that must be achieved for a state to terminate Medicaid for administrative reasons should represent average state performance before the pandemic.
3. No state should be allowed to terminate a Supplemental Nutrition Assistance Program (SNAP) recipient who is a child, a pregnant or post-partum beneficiary, or an expansion adult, unless recent records show income above Medicaid levels.

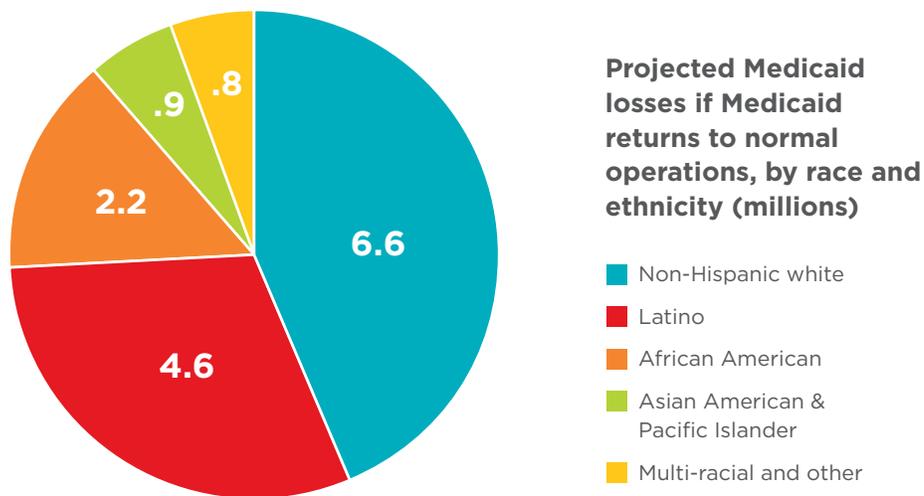
America's low-income families are rapidly approaching a massive Medicaid cliff. It cannot be avoided entirely. But federal action can dramatically shrink the magnitude of loss, protecting health care for millions of eligible people, most of whom live in communities of color.

Figure 1: If Medicaid returns to normal operations, terminations will far exceed past Medicaid losses and coverage denials



Sources: ASPE 2022; UnidosUS, Families USA, First Focus on Children 2022; Center on Budget and Policy Priorities 2021.

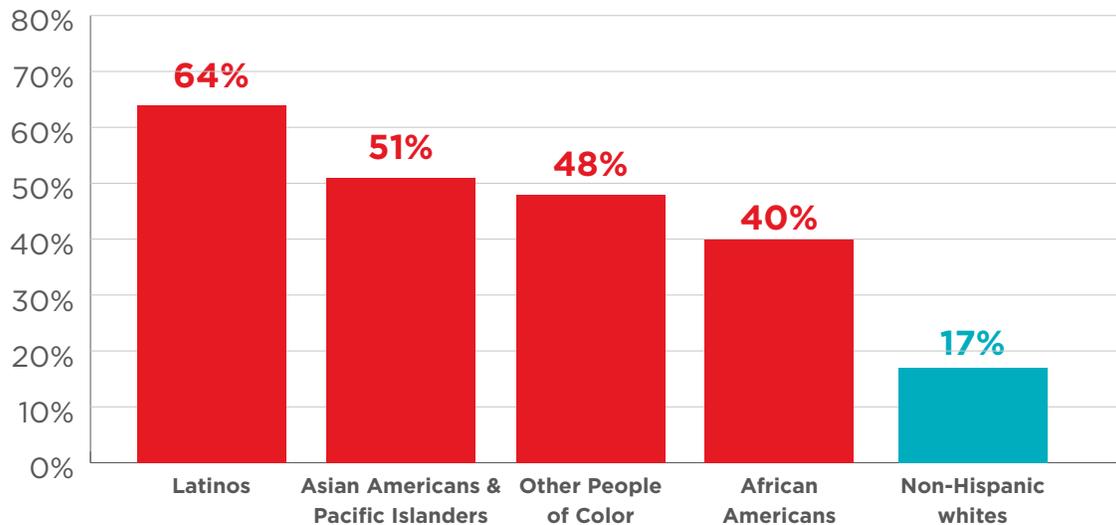
Figure 2: If Medicaid returns to normal operations, people of color will suffer disproportionate harm



Source: ASPE 2022. Note: Latinos include Hispanics of all races. All racial and ethnic categories other than “Latino” are limited to non-Hispanics.

Figure 3: If Medicaid returns to normal operations, red-tape terminations will be inequitably distributed

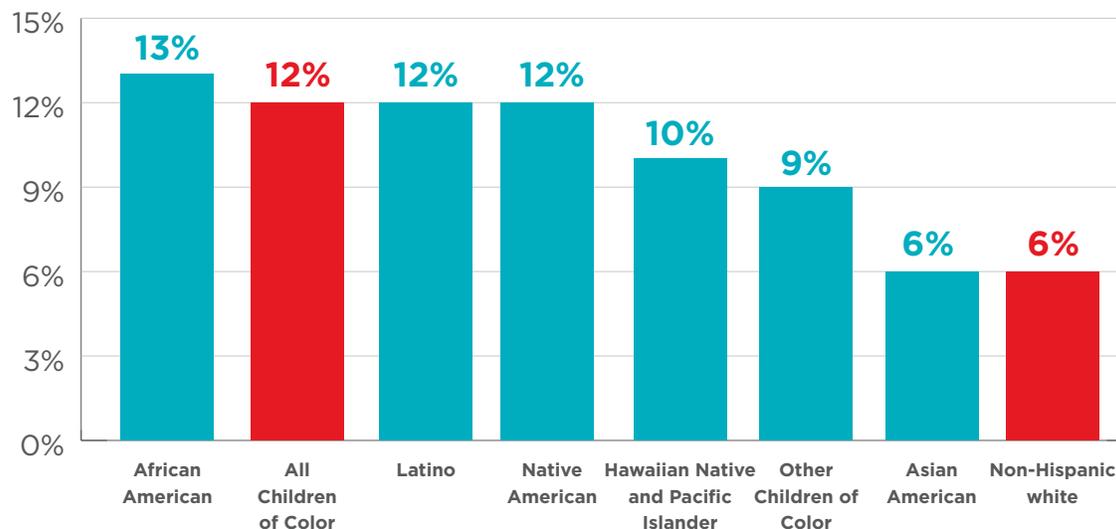
Percentage of people projected to lose Medicaid who will be terminated for administrative reasons, despite remaining eligible, by race and ethnicity



Source: ASPE 2022. Note: Latinos include Hispanics of all races. All racial and ethnic categories other than "Latino" are limited to non-Hispanics.

Figure 4: If Medicaid returns to normal operations, children in many communities of color will experience widespread and disproportionate harm

Among all children living in the United States, the percentage who are likely to lose Medicaid once terminations begin, by race and ethnicity, if past policies are in effect

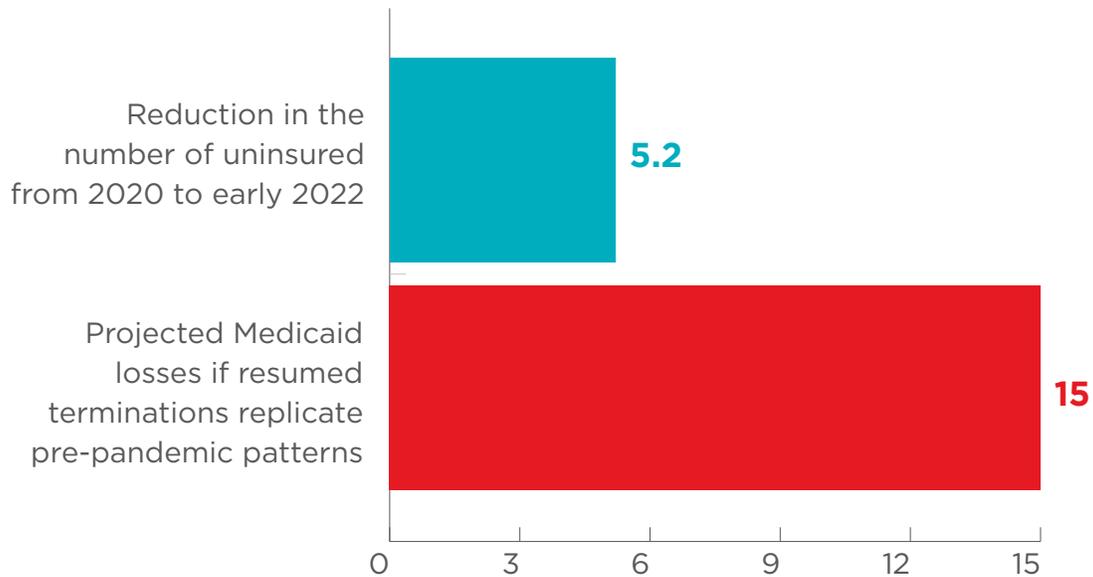


Source: UnidosUS, Families USA, First Focus on Children 2022. Note: Children of color are all children except non-Hispanic whites. Latinos include Hispanics of all races. All racial and ethnic categories other than "Latino" and "Children of Color" are limited to non-Hispanics.



Figure 5: If Medicaid redeterminations return to normal, pre-pandemic operations, Medicaid losses could offset or erase recent years' coverage gains

Projected Medicaid losses if the program returns to normal, pre-pandemic operations, compared to coverage gains from 2020 to 2022 (millions)



Sources: ASPE 2022. Note: Projected Medicaid losses include both people who become uninsured and those who transition to other sources of coverage.



Millions of Families Who Rely on Medicaid for Health Care Are at Risk

In the Families First Coronavirus Relief Act, Congress gave state Medicaid programs a significant increase in federal funding. Every state's federal matching percentage rose by 6.2 points. In exchange, maintenance of effort requirements forbade states from terminating anyone's coverage, unless they died, moved out of state, or requested termination. Both the funding and the corresponding continuous coverage requirement were set to last until the end of the PHE.

As a result, the number of people covered through Medicaid grew from 64 million in February 2020 to 83.5 million in August 2022—a 31% increase (Figure 6).⁸ Whenever the continuous coverage requirement ends, state Medicaid agencies, many of which are understaffed, will face history's largest backlog of Medicaid redeterminations.

If such redeterminations operate as in the past, many families are likely to remain eligible but lose Medicaid because of red tape and paperwork requirements. Experience from Utah provides a grim preview of what could happen.⁹ When the state's separate CHIP program redetermined eligibility program-wide in 2021, more than 40% of all children were terminated. For 85% of these children, the state had no idea whether they remained eligible. They lost coverage because the state never got a response to letters requesting completion of renewal forms.

Similar patterns of widespread, paperwork-driven terminations of people who may have been eligible played out in state after state before the pandemic, as the number of uninsured children and families rose from 2017 to 2019.¹⁰

For example:

- When Texas ended health coverage for nearly 150,000 children, more than 90% of coverage losses resulted from the state not receiving a response to its requests for renewal paperwork.¹¹
- 85% of Medicaid terminations in Louisiana took place without any state determination of eligibility. Termination resulted when the state did not receive the requested paperwork from families. The state therefore anticipated that 160,000 people could lose Medicaid when the PHE ended.¹²
- Tennessee's Medicaid program terminated 11,000 children because they were ineligible. The state terminated nearly 13 times as many children—140,000—because the state did not receive prompt and complete responses to lengthy renewal packets sent to each family.¹³

It is thus not surprising that ASPE found that significant losses, often terminating coverage for people who continued to qualify, would result if Medicaid returned to typical, pre-pandemic operations when COVID-19 continuous coverage requirements end. The magnitude of those estimated losses, however, was staggering. Not just the overall Medicaid terminations discussed above, but terminations experienced by each community of color analyzed by ASPE would eclipse the community's greatest past Medicaid losses and coverage denials (Figure 7):

- The largest previous one-year Medicaid loss for Latinos took place in 2019, when the number enrolled fell by 600,000. Coincidentally, roughly the same number of uninsured Latinos (600,000) are denied Medicaid because they fall into the "Medicaid coverage gap," living in states that refuse to expand Medicaid. Projected losses following the end of COVID coverage requirements are an order of magnitude larger: an estimated 4.6 million Latinos will lose Medicaid, if the program returns to standard, pre-pandemic patterns.
- The largest one-year Medicaid loss experienced by African Americans took place in 1997, one year after the passage of federal welfare legislation, when the number of Black people covered through Medicaid fell by 800,000. Slightly fewer African Americans, 600,000, are currently denied coverage because of the Medicaid coverage gap. By contrast, fully 2.2 million African Americans are projected to lose Medicaid once continuous coverage requirements expire.
- Nearly a million Asian Americans and Pacific Islanders (900,000) are likely to lose Medicaid if the program returns to normal operations—literally three times the size of the largest Medicaid loss these communities have ever experienced, when Medicaid coverage fell by 300,000 in 2019.



ASPE also found that 5.3 million children will lose Medicaid, three-quarters of whom will remain eligible but be terminated because of missing paperwork or other administrative reasons. The largest previous one-year drop in children's Medicaid took place in 2019, when the number covered through Medicaid fell by 1.4 million—less than a third of the level anticipated if Medicaid returns to normal, pre-pandemic operations.¹⁴

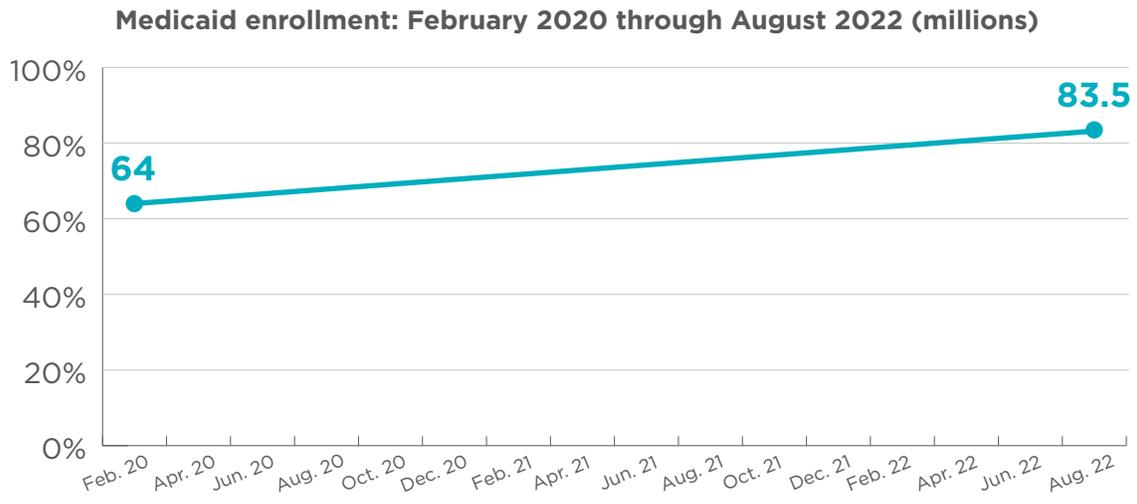
When programs like Medicaid require families to run a paperwork obstacle course to obtain or retain benefits, the community members most likely to be shut out are precisely those most likely to need and qualify for benefits.

The Office of Management and Budget explained the impact of administrative burdens as follows:

Administrative burdens include “[not only] time spent on applications and paperwork, but also factors like time spent traveling to in-person visits, answering notices and phone calls to verify eligibility, navigating web interfaces, and collecting any documentation required to prove eligibility. [Such burdens] do not fall equally on all entities and individuals, leading to disproportionate underutilization of critical services and programs as well as unequal costs of access, often by the people and communities who need them the most. Burdens that seem minor when designing and implementing a program can have substantial negative effects for individuals already facing scarcity.”¹⁵

If federal policymakers do not take effective action, America may see its greatest health care loss in history, disproportionately harming communities of color, in significant part due to nothing more than needless red tape. Fortunately, federal leaders can and therefore must take effective action.

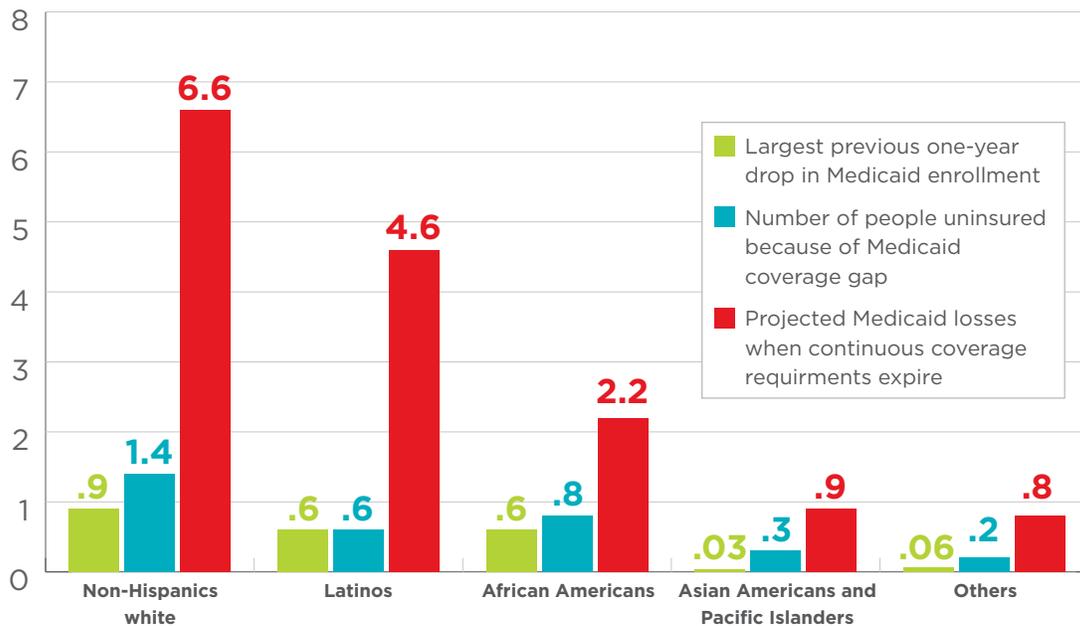
Figure 6: After COVID-19 coverage protections took effect, Medicaid enrollment rose by nearly a third (31%)



Source: CMS 2022.

Figure 7: If Medicaid returns to normal operations, coverage losses will far exceed past losses and coverage denials, for each racial and ethnic group shown in available data

Projected Medicaid terminations following a return to normal operations, compared to past Medicaid losses and coverage denials, by race and ethnicity (millions)



Sources: U.S. Census Bureau 2022; Analysis of CPS data for 1979-2017, accessed through PUMS-CPS, University of Minnesota, www.ipums.org; Center on Budget and Policy Priorities 2021; ASPE 2022. Note: Latinos include Hispanics of all races. All racial and ethnic categories other than "Latino" are limited to non-Hispanics.



Federal Policymakers Can Preserve Health Care for Millions of Families by Setting and Enforcing Clear Expectations for States That Protect Eligible People

States' Performances Varied Greatly before the Pandemic

Leading experts¹⁶ agree that the “most important single step states and CMS [the Centers for Medicare and Medicaid Services] can take to avoid coverage losses” is to increase electronic eligibility redeterminations that renew coverage based on data matches showing continued eligibility, thereby eliminating the requirement for families to complete paperwork. Sometimes termed “administrative” or “*ex parte*” renewal, this process has the state send the family a notice describing the reasons it found them eligible for Medicaid. The notice explains that the family is legally obligated to tell the state if the information on the notice is mistaken. Coverage continues unless the Medicaid program hears from the family or obtains other information showing ineligibility. This form of renewal makes coverage rather than termination the default response if the state does not hear back from a beneficiary.

Before the pandemic, states with the highest levels of *ex parte* renewal were politically diverse: in nine states, ranging from Alabama and Idaho to Colorado and Rhode Island,¹⁷ electronic data matches were responsible for 75% or more of all Medicaid renewals as of January 2020.¹⁸ By contrast, 10 other states either used data matches for less than 25% of all renewals or did not use them at all.¹⁹ The latter states were also diverse in their general governing philosophies, including Nevada and New Jersey as well as Missouri and Texas.

If all states raised *ex parte* renewals to the levels achieved by their peers, the number of eligible people losing coverage for procedural or administrative reasons would be far below the level anticipated by ASPE. As we explain next, targeted modifications to the Medicaid statute could bring about such results.

Congress Should Prevent Eligible Families from Losing Medicaid by Establishing Clear Standards for States and Giving CMS Credible Authority to Protect Families

Three changes are essential:

1. *If a state is failing to meet outcome standards or if CMS finds that state policy is causing the preventable termination of Medicaid for eligible beneficiaries, the state's administrative terminations should be placed on hold.*

Under this approach, a state could end a beneficiary's Medicaid, despite the hold, if the state finds that the beneficiary does not meet the program's eligibility requirements. But if the state does not know whether a beneficiary has become ineligible, it would not be permitted to terminate the beneficiary due to missing paperwork alone. Once the state meets redetermination outcome standards and CMS finds that the state's revised policies would no longer cause preventable termination of eligible people, the hold would end.

Today, CMS's only remedy for a state's violation of its redetermination duties is to deny federal matching funds. Denying large amounts of such funding may not be a credible deterrent to state misconduct, however. CMS's use of that remedy may appear unlikely, since denying significant federal funding often harms families and health care providers, not just state governments.²⁰ By contrast, pausing administrative terminations pending the state's course correction would protect eligible families, without curtailing federal funding. And if the hold is based on a state's failure to meet outcome standards, CMS can take action without making subjective determinations potentially subject to court challenge.

2. *States should be required to achieve clearly defined outcomes that represent average or median state performance before the pandemic.*

That would mean:

- At least 50% of each state's renewals must be based on data matches showing continued eligibility, rather than paperwork furnished by beneficiaries.²¹
- No more than 45% of any state's terminations could be caused by missing paperwork or other administrative factors. At least 55% would need to result from the state gathering enough information with which to conclude that a beneficiary was ineligible.²²

States should be required to report monthly redetermination outcomes publicly. Currently, only private reports to CMS are required. States should release data in preliminary and final form, coming as close as possible to real-time transparency while making clear that initial data reports are subject to later revision.

Some states will face challenges in quickly reaching median or average levels of pre-pandemic performance. However, federal policymakers should be limited in their willingness to accommodate those challenges when they result from questionable state policy decisions that have persisted since the ACA's full implementation nearly a decade ago.

These policy decisions include:

- Ignoring the ACA's legal requirement to renew eligibility based on data matches, to the maximum extent possible.²³
- Refusing to take full advantage of 90% federal funding for information technology (IT) improvements to Medicaid systems for eligibility, enrollment, and renewal.²⁴

Eligible families should not have their coverage terminated because of paperwork requests that would have been unnecessary had the state chosen to comply with the ACA and seek available federal resources. Instead, administrative terminations should automatically be suspended if a state does not meet outcome standards that are more than reasonable 13 years after the ACA's enactment.

Under our proposed policy, states that want the ability to terminate beneficiaries administratively would have an incentive to meet their outcome targets as quickly as possible.

3. *No state should be allowed to terminate a child, a pregnant or post-partum person, or an expansion adult who receives SNAP benefits, unless data more recent than the SNAP eligibility determination shows income above Medicaid or CHIP levels.*

Under the proposed policy, a state could not terminate such a SNAP recipient administratively for failing to respond to a request for renewal information, unless individualized data shows likely ineligibility.

Such a policy would improve program integrity by increasing the accuracy of redetermination outcomes. An estimated 97% of SNAP recipients under age 65 qualify for Medicaid as children or expansion-eligible adults.²⁵ Requiring renewal rather than administrative termination for this group of people—SNAP recipients for whom the state has no evidence of ineligibility—would prevent numerous erroneous terminations.²⁶

This policy would be administratively feasible. Almost every state already uses some SNAP data to make eligibility decisions.²⁷ As noted earlier, states could claim 90% federal funding for IT needed for Medicaid eligibility systems to automate renewal based on SNAP, provided the development benefited only the Medicaid program and not the SNAP program as well.²⁸ But even before IT improvements take effect, simply giving Medicaid case workers look-up rights to base renewal on SNAP receipt achieves some administrative savings, based on past state experience.²⁹ States have achieved other major gains by using batch files and spreadsheets to share information between programs, without IT procurement or major systems changes.³⁰

Preserving Medicaid for SNAP recipients would protect numerous eligible families. Roughly half of all Medicaid beneficiaries receive SNAP (49%), including 55% of Medicaid-enrolled children, 60% of American Indian/Alaskan Native beneficiaries, and 63% of all African Americans who rely on Medicaid for their health care (Table 1). When those categories overlap, the protection is even greater; for example, 70% of Medicaid’s African American children participate in SNAP.

Table 1:
The percentage of Medicaid beneficiaries, by age, race, and ethnicity, who receive benefits from the SNAP (2018)

| | Non-Hispanic white | Latino | African American | Asian American and Pacific Islander | American Indian and Alaska Native | Multiple Races | All Races and Ethnicities Combined |
|----------------------------|--------------------|--------|------------------|-------------------------------------|-----------------------------------|----------------|------------------------------------|
| Children ages 0-18 | 51% | 52% | 70% | 37% | 61% | 66% | 55% |
| Adults ages 19-64 | 44% | 35% | 57% | 23% | 60% | 54% | 43% |
| Adults ages 65+ | 33% | 49% | 70% | 27% | n/a | n/a | 39% |
| Total beneficiaries | 46% | 45% | 63% | 28% | 60% | 56% | 49% |

Source: Analysis by Jameson Carter of microsimulation estimates from the Urban Institute’s [Transfer Income Model, version 3 \(TRIM3\)](#). Note: The Methodological Appendix, below, explains how these estimates were derived. “N/A” means that the national survey on which TRIM3 was based did not contain a large enough sample to yield reliable estimates. Latinos are Hispanics of all races. African Americans, Asian Americans and Pacific Islanders, American Indians and Alaska Natives, and people with multiple races are limited to people who are not Hispanic.



Conclusion

The 117th Congress will soon conclude, as the Biden Administration completes its first two years in office. This brief interval has seen remarkable improvements to American health coverage. In less than 24 months, federal policymakers have increased financial assistance for families who buy their own insurance in ACA marketplaces, have made history's greatest investments in outreach and application assistance, and have stabilized Medicaid coverage as the country grappled with the worst outbreak of infectious disease in more than a century.

The blessings of health coverage now reach more people in America than ever before. Our country's leaders have focused significant assistance where it counted most: on hardworking families in historically disadvantaged communities. But those hard-won gains will disappear if states are permitted to terminate Medicaid as they did in the past. To prevent this recent health care progress from being nullified by health equity disaster, federal policymakers must enact Medicaid reforms to prevent millions of eligible families from being terminated because of nothing more than missing paperwork.



Methodological Appendix for Table 1

By Jameson Carter*

The results reported in Table 1 were obtained using a methodology utilized by the Congressional Research Service, an expert federal agency that serves Congress.³¹ The 2019 Annual Social and Economic Supplement (ASEC) to the Current Population Survey was used to obtain Medicaid enrollment status in 2018, while the Urban Institute's Transfer Income Model (TRIM) model was used to obtain SNAP enrollment status in 2018. This methodology imperfectly reflects the true overlap of SNAP and Medicaid co-enrollment but provides the best national information available to researchers. The following sections summarize the methods used and decisions made in conducting this analysis.

Data Sources and Undercounts in SNAP/Medicaid

The ASEC is a national survey of more than 75,000 households that asks households to answer various demographic and socioeconomic questions, including whether they receive federal benefits such as SNAP and Medicaid. However, such benefits are often underreported.³² TRIM addresses SNAP underreporting in the ASEC by estimating whether a SNAP unit (which itself is a construct defined by the Urban Institute) is eligible for and receives benefits. These estimates are made to hit administrative targets, such that the TRIM-augmented ASEC represents the actual composition of SNAP receipt across household types, benefit amounts, states of residence, and citizenship statuses.³³ Unfortunately, similar protocols are unavailable within TRIM for Medicaid, so this analysis undercounts the Medicaid caseload by roughly 25%.³⁴

* Mr. Carter is a Graduate Research Assistant at Carnegie Mellon University. He is a former Data Science Fellow at the U.S. Internal Revenue Service and Research Assistant at the Congressional Research Service. He has a bachelor's degree in economics from Carleton College and expects to receive a master's degree in 2023 from the Heinz College of Information Systems and Public Policy at Carnegie Mellon University.

Various reasons have been cited for the undercount, which reflects reporting errors made by respondents who incorrectly characterize their insurance status.³⁵ Some studies have shown that adults with higher incomes and shorter spells of coverage are less likely to report their coverage in surveys.³⁶ Therefore, the true nature of co-enrollment across demographic groups may not be reflected in the results reported in this paper. Further, data representing 2018 co-enrollment is not fully representative of the current landscape but is the most recent data for which TRIM3 estimates are available.

Definitions of Demographic Considerations

Responses from the ASEC survey were used to define racial and ethnic concepts, concepts that are by nature subjective. The Census Bureau itself acknowledges that these definitions, “reflect a social definition of race recognized in this country and [are] not an attempt to define race biologically, anthropologically, or genetically.”³⁷ The method used in this paper categorizes individuals according to both their race and ethnicity, such that Latino individuals are considered as such regardless of their racial identity. Prioritizing ethnicity over race may not reflect how respondents view their identity and relies, instead, on standards set by the Census Bureau.

Similarly, responses from the ASEC were used to define age. Cutoffs were set in Table 1 to reflect common notions of age that are reflected in Medicaid eligibility categories. Children were defined as anyone age 18 or younger; they were compared both to adults ages 19-64 and retirement-age adults ages 65 and up.

Definitions of Medicaid and SNAP Co-Enrollment

This analysis defines a person as having received SNAP if they received benefits at any point during the year. Similarly, a person is counted as having received Medicaid if they were covered at any point during the year. This definition does not make distinctions between people who heavily benefit from these programs and those who received relatively marginal benefits.

Standard Errors

Estimates reported here are derived from a sample, which can be subject to multiple forms of error. Conventionally, standard errors are used in social research settings to estimate how much specific estimates might deviate from the reality experienced by individuals nationwide. However, this convention is not necessarily applicable to situations where a sample such as the ASEC is taken once. By using successive difference replicate weights (which “allow a single sample to simulate multiple samples, thus generating more informed standard error estimates”), this analysis is better able to estimate the true standard error.³⁸ Below we report the standard errors of the estimates reported above, as well as the confidence intervals associated with them.

Table A1:
Standard Errors for Table 1’s estimated percentage of Medicaid beneficiaries, by age, race, and ethnicity, who receive benefits from SNAP (2018)

| | Non-Hispanic white | Latino | African American | Asian American | American Indian and Alaska Native | Multiple Races | All Races and Ethnicities Combined |
|---------------------|--------------------|--------|------------------|----------------|-----------------------------------|----------------|------------------------------------|
| Children ages 0-18 | 1.1% | 1.1% | 1.8% | 3.8% | 5.5% | 3.2% | .8% |
| Adults ages 19-64 | .9% | 1% | 1.5% | 2% | 4.4% | 3.2% | .6% |
| Adults ages 65+ | 2.2% | 3.1% | 2.9% | 4.2% | n/a | n/a | 1.5% |
| Total beneficiaries | .7% | .9% | 1.4% | 2.1% | 4.1% | 2.6% | .5% |

Source: Analysis of microsimulation estimates from the Urban Institute’s [Transfer Income Model, version 3 \(TRIM3\)](#). Analysis conducted in R using the survey package’s replicate weight capabilities.

Table A2:
95% confidence intervals for Table 1’s estimated percentage of Medicaid beneficiaries, by age, race, and ethnicity, who receive benefits from SNAP (2018)

| | Non-Hispanic white | Latino | African American | Asian American | American Indian and Alaska Native | Multiple Races | All Races and Ethnicities Combined |
|---------------------|--------------------|----------------|------------------|----------------|-----------------------------------|----------------|------------------------------------|
| Children age 0-18 | 48.5% to 52.7% | 50% to 54.2% | 66.4% to 73.4% | 29.9% to 44.8% | 49.9% to 71.4% | 59.5% to 72% | 53.8% to 56.7% |
| Adults age 19-64 | 42.5% to 46% | 32.8% to 36.9% | 54.5% to 60.5% | 18.5% to 26.2% | 51% to 68.1% | 47.6% to 60% | 42.2% to 44.6% |
| Adults age 65+ | 28.4% to 37.1% | 42.9% to 55% | 47% to 58.5% | 18.3% to 34.7% | n/a | n/a | 36.4% to 42.2% |
| Total beneficiaries | 44.5% to 47.4% | 43.5% to 46.9% | 60.6% to 66% | 23.4% to 31.6% | 51.8% to 67.7% | 56.2% to 66.3% | 47.7% to 49.8% |

Source: Analysis of microsimulation estimates from the Urban Institute’s [Transfer Income Model, version 3 \(TRIM3\)](#). Analysis conducted in R using the survey package’s replicate weight capabilities.

About APIAHF

The Asian & Pacific Islander American Health Forum (APIAHF) is the nation's oldest and largest health advocacy organization working to advance the health and well-being of over 25 million Asian Americans, Native Hawaiians, and Pacific Islanders across the U.S. and territories. APIAHF influences policy, mobilizes communities and strengthens programs and organizations to improve the health of Asian Americans, Native Hawaiians and Pacific Islanders.

About Coalition on Human Needs

The Coalition on Human Needs (CHN) is an alliance of national organizations working together to promote public policies which address the needs of low-income and other vulnerable populations.

The Coalition's members include civil rights, religious, labor, and professional organizations, service providers and those concerned with the well-being of children, women, the elderly, and people with disabilities.

About The Leadership Conference

The Leadership Conference on Civil and Human Rights is a coalition charged by its diverse membership of more than 230 national organizations to promote and protect the rights of all persons in the United States. The Leadership Conference works toward an America as good as its ideals. For more information on The Leadership Conference and its member organizations, visit www.civilrights.org.

About NAACP

Founded in 1909 in response to the ongoing violence against Black people around the country, the NAACP (National Association for the Advancement of Colored People) is the largest and most pre-eminent civil rights organization in the nation. We have over 2,200 units and branches across the nation, along with well over 2M activists. Our mission is to secure the political, educational, social, and economic equality of rights in order to eliminate race-based discrimination and ensure the health and well-being of all persons.

NOTE: The Legal Defense Fund—also referred to as the NAACP-LDF was founded in 1940 as a part of the NAACP, but separated in 1957 to become a completely separate entity. It is recognized as the nation's first civil and human rights law organization and shares our commitment to equal rights.

About National Urban League

The National Urban League is a historic civil rights organization dedicated to economic empowerment in order to elevate the standard of living in historically underserved urban communities. Founded in 1910 and headquartered in New York City, the National Urban League spearheads the efforts of its local affiliates through the development of programs, public policy research, and advocacy. Today, the National Urban League has 92 affiliates serving 300 communities in 36 states and the District of Columbia, providing direct services that impact and improve the lives of more than two million people nationwide.

About UnidosUS

UnidosUS, previously known as NCLR (National Council of La Raza), is the nation's largest Hispanic civil rights and advocacy organization. Through its unique combination of expert research, advocacy, programs, and an [Affiliate Network](#) of nearly 300 community-based organizations across the United States and Puerto Rico, UnidosUS simultaneously challenges the social, economic, and political barriers that affect Latinos at the national and local levels.

For more than 50 years, UnidosUS has united communities and different groups seeking common ground through collaboration, and that share a desire to make our country stronger. For more information on UnidosUS, visit www.unidosus.org or follow us on [Facebook](#), [Instagram](#), and [Twitter](#).

Authorship

This report was authored by Stan Dorn, Health Policy Director for UnidosUS.

Endnotes

- 1 Assistant Secretary for Planning and Evaluation, Office of Health Policy (ASPE OHP), “Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches,” HP-2022-20, Issue Brief, August 19, 2022, https://www.aspe.hhs.gov/sites/default/files/documents/60f0ac74ee06eb578d30b0f39ac94323/aspe-end-mcaid-continuous-coverage.pdf?_ga=2.47335719.1429122297.1668138950-1864737861.1662580005.
- 2 Analysis of U.S. Census Bureau, “Table HHI-01. Health Insurance Coverage Status and Type of Coverage—All Persons by Sex, Race and Hispanic Origin: 2017 to 2021,” Current Population Survey, Annual Social and Economic Supplement (CPS ASEC) 2018 Bridge file, and 2019 to 2022 Production file, <https://www2.census.gov/programs-surveys/demo/tables/health-insurance/time-series/hic/hhi01.xlsx>. For analysis of CPS ASEC health coverage data through 2017, see Stan Dorn, “The Looming Equity Crisis in Children’s Health Care: Federal and State Action Is Needed to Prevent Millions of Children from Losing Medicaid,” Families USA, First Focus on Children, UnidosUS, July 2022, https://www.unidosus.org/wp-content/uploads/2022/07/unidosus_the looming equity crisisinchildrenshealthcare_71422.pdf.
- 3 Gideon Lukens and Breanna Sharer, “Closing Medicaid Coverage Gap Would Help Diverse Group [sic] and Narrow Racial Disparities,” Center on Budget and Policy Priorities, revised June 14, 2021, <https://www.cbpp.org/sites/default/files/6-10-21health.pdf>.
- 4 The terms “Hispanic” and “Latino” are used interchangeably by the U.S. Census Bureau and throughout this document to refer to persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, Spanish, and other Hispanic descent; they may be of any race.
- 5 Dorn, “The Looming Equity Crisis in Children’s Health Care,” UnidosUS, July 18, 2022, <https://www.unidosus.org/publications/the-looming-equity-crisis-in-childrens-health-care/>.
- 6 One 2008 overview summarized research findings as follows: “Substantial evidence exists regarding the potential harmful impact that loss of Medicaid insurance, whether through lost eligibility or drop out, can have. In many cases when someone loses Medicaid coverage, the insurance is not immediately replaced by an alternative, thus rendering a large population, at least temporarily, uninsured. Even after accounting for potentially confounding factors, loss in coverage is associated with discontinuity of care, reduced ambulatory care use, increased emergency room use, higher health care costs, and worse patient outcomes. Furthermore, children of adults who lose Medicaid may themselves be affected through ‘spillover effects’ and are more likely to be uninsured despite their eligibility for coverage.” Milda R. Saunders and Caleb Alexander, “Turning and Churning: Loss of Health Insurance Among Adults in Medicaid,” *J Gen Intern Med* 24, no. 1 (2008): 133–4, <https://link.springer.com/article/10.1007/s10903-021-01178-8>. Since then, one particularly poignant study found Medicaid disenrollment to be “associated with a 3.3-percentage point increase in late stage of [breast cancer] at the time of diagnosis.” See Wafa W. Tarazi, Cathy J. Bradley, Harry D. Bear, David W. Harless, Lindsay M. Sabik, “Impact of Medicaid Disenrollment in Tennessee on Breast Cancer Stage at Diagnosis and Treatment,” *Cancer*, September 1, 2017, <https://acsjournals.onlinelibrary.wiley.com/doi/pdf/10.1002/cncr.30771>. See also Nicole Lurie, Nancy B. Ward, Martin F. Shapiro, and Robert H. Brook, “Special Report: Termination from Medicaid—Does it Affect Health,” *New England Journal of Medicine* 311:7 (480-484), Aug. 16, 1984, finding that adult hypertensives losing Medicaid coverage experienced an average increase in diastolic blood pressure associated with a 40% increased risk of death if sustained.
- 7 Aiden Lee, Joel Ruhter, Christie Peters, Nancy De Lew, and Benjamin D. Sommers, “National Uninsured Rate Reaches All-Time Low in Early 2022,” HP-2022-23, ASPE OHP, *Data Point*, August 2022, <https://aspe.hhs.gov/sites/default/files/documents/15c1f9899b3f203887deba90e3005f5a/Uninsured-Q1-2022-Data-Point-HP-2022-23-08.pdf>.
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- 10 U.S. Census Bureau, “Table HHI-01; Sarah Sugar, Christie Peters, Nancy De Lew, and Benjamin D. Sommers, “Medicaid Churning and Continuity of Care: Evidence and Policy Considerations before and after the COVID-19 Pandemic,” HP-2021-10, ASPE Office of Health Policy, April 12, 2021, <https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf>. For broader context and further examples, see Emmett Ruff and Eliot Fishman, “The Return of Churn: State Paperwork Barriers Caused More than 1.5 Million Low-Income People to Lose Their Medicaid Coverage in 2018,” Families USA, April 2019, https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf.
- 11 Ruff and Fishman, The Return of Churn; Allie Morris, “Texas Kicks Thousands of Low-Income Children off Medicaid over Missing Paperwork,” *San Antonio Express News*, March 29, 2019, <https://www.expressnews.com/news/politics/texas-legislature/article/Texas-kicks-thousands-of-low-income-children-off-13727929.php>.
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- 13 See Table 1 in Tennessee Comptroller of the Treasury, “Performance Audit Report: Special Project: Division of TennCare’s Redetermination Process and the Impact on Children’s Enrollment,” February 2020, <https://www.documentcloud.org/documents/6770443-TennCare-Audit.html>.
- 14 Dorn, “The Looming Equity Crisis in Children’s Health Care.”
- 15 Executive Office of the President, Office of Management and Budget, “Study to Identify Methods to Assess Equity: Report to the President, Office of Management and Budget, July 2021, https://www.whitehouse.gov/wp-content/uploads/2021/08/OMB-Report-on-E013985-Implementation_508-Compliant-Secure-v1.1.pdf.
- 16 Kinda Serafi, Cindy Mann, and Nina V. Pudukollu, “The Risk of Coverage Loss for Medicaid Beneficiaries as the COVID-19 Public Health Emergency Ends,” Manatt Health for The Commonwealth Fund, September 23, 2021, https://www.commonwealthfund.org/blog/2021/risk-coverage-loss-medicaid-beneficiaries-covid-19?utm_source=alert&utm_medium=email&utm_campaign=Achieving+Universal+Coverage.
- 17 Other states in this category were Arkansas, the District of Columbia, Michigan, North Carolina, and Ohio.
- 18 Tricia Brooks, Lauren Roygardner, Samantha Artiga, Olivia Pham, and Rachel Dolan, “Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey,” Table 10, Georgetown University Center for Children and Families and the Kaiser Family Foundation, March 2020, <https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf>.
- 19 Missouri, Nebraska, New Hampshire, New Jersey, Texas, West Virginia, and Wisconsin used data matches for fewer than 25% of all renewals. Maine, Nevada, and Wyoming did no electronic renewals. Alaska, Delaware, North Dakota, South Carolina, and Tennessee did not report these renewal outcomes.
- 20 Another problem is that it is not clear how much federal financial participation CMS can deny to a state that is spending less because eligible people are improperly terminated.
- 21 Based on the above study by the Georgetown Center for Children and Families and the Kaiser Family Foundation, the median state in 2020 used data matches for 50% of renewals.
- 22 ASPE’s analysis showed that, from March 2015 through November 2016, 45% of Medicaid terminations involved people who qualified but lost coverage administratively. That figure likely underestimates average administrative terminations, since some people who lost eligibility may have been terminated because of missing paperwork.
- 23 See ACA §1413(c)(3); 42 C.F.R. 435.916(a).
- 24 See CMS, “Mechanized Claims Processing and Information Retrieval Systems-Enhanced Funding,” SMD # 16-004, March 31, 2016, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16004.pdf>.

- 25 See Stan Dorn, Laura Wheaton, Paul Johnson, Lisa Dubay, “Using SNAP Receipt to Establish, Verify, and Renew Medicaid Eligibility,” The Urban Institute, May 2013, <https://www.urban.org/sites/default/files/publication/23566/412808-Using-SNAP-Receipt-to-Establish-Verify-and-Renew-Medicaid.PDF>. The categories analyzed in the cited research are limited to children and expansion adults. Compared to the latter, a higher likelihood of eligibility would apply to coverage of pregnant and post-partum adults, since their eligibility extends above 138% of the federal poverty level, the eligibility threshold for expansion adults.
- 26 Research suggests that, whenever a group of beneficiaries is known to have even a 90% likelihood of eligibility, eligibility errors decline by more than 50% when administrative renewal rather than administrative termination becomes the default if beneficiaries do not respond to information requests. Stan Dorn and Matthew Buettgens, “Administrative Renewal, Accuracy of Redetermination Outcomes, and Administrative Costs,” Urban Institute, October 2013, <https://www.urban.org/sites/default/files/publication/24031/412921-Administrative-Renewal-Accuracy-of-Redetermination-Outcomes-and-Administrative-Costs.PDF>.
- 27 CMS, “Medicaid/CHIP Eligibility Verification Plans,” accessed December 7, 2022, <https://www.medicaid.gov/medicaid/eligibility/medicaidchip-eligibility-verification-plans/index.html>.
- 28 If both programs benefited, costs would need to be allocated between the two programs. The federal government’s 90% share would apply only to the portion of costs allocated to Medicaid.
- 29 This was Alabama’s experience implementing Express Lane Eligibility to renew children’s Medicaid eligibility automatically based on SNAP receipt. The state achieved modest administrative savings when case workers could look up a child’s SNAP case record and renew coverage when the child was found to benefit from SNAP. However, those savings became much more significant after the state implemented systems changes enabling SNAP-based renewals to happen automatically, without any need for caseworker involvement. See Margaret Wilkinson, Brigette Courtot, and Ian Hill, “CHIPRA Express Lane Eligibility Evaluation, Case Study of Alabama’s Express Lane Eligibility: Final Report,” Urban Institute/Mathematica Policy Research, January 13, 2014, <https://www.urban.org/sites/default/files/publication/59791/2000281-CHIPRA-Express-Lane-Eligibility-Evaluation-Case-Study-of-Alabama%E2%80%99s-Express-Lane-Eligibility.pdf>.
- 30 Beginning as a pilot in 2005, Arizona has used batch files and secure transmission of Excel files to convey information from prisons and jails to the Medicaid program. This data exchange makes it possible for people reentering the community to have Medicaid active the moment they leave prison or jail, preventing brief gaps in medication and other essential health care that, in other states, often yield grim results. See Jesse Janetta, Stan Dorn, Emma Kurs, Travis Reginal, Jeremy Marks, Kinda Serafi, Jocelyn Guyer, and Christopher Cantrell, “Strategies for Connecting Justice Involved Populations to Health Coverage and Care,” Urban Institute and Manatt Health, March 2018, https://www.urban.org/sites/default/files/publication/97041/strategies_for_connecting_justice-involved_populations_to_health_coverage_and_care.pdf, citing Jane B. Wishner and Kamala Mallik-Kane, “Information Sharing between Medicaid and Corrections Systems to Enroll the Justice-Involved Population, Arizona and Washington: Medicaid Areas of Flexibility to Provide Coverage and Care to Justice Involved Populations,” Urban Institute, 2017, https://www.urban.org/sites/default/files/publication/97036/connecting_criminal_justice-involved_people_with_medicaid_coverage_and_services_innovative_strategies_from_arizona.pdf.
- 31 Gene Falk and Jameson A. Carter, Need-Tested Benefits: Technical Companion to Selected CRS Reports on Need-Tested Benefits Receipt by Families and Individuals, United States Congressional Research Service, R-46824, Washington, DC: CRS, 2021, <https://crsreports.congress.gov/product/pdf/R/R46824>.
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- 37 United States Census Bureau, “About the Topic of Race,” Census.gov, <https://www.census.gov/topics/population/race/about.html>.
- 38 Minnesota Population Center, “Replicate Weights in the Current Population Survey,” CPS IPUMS, <https://cps.ipums.org/cps/repwt.shtml>.

