



May 2026

Latino families' health care under attack



Latino families' health care under attack:

Rather than build on the Affordable Care Act's gains, Congress and the administration are terminating families' insurance and raising their health care costs¹

Executive summary

For 14 years from the Affordable Care Act's (ACA) enactment in 2010 through 2024 the Latino² community made significant gains in health coverage, improving access to health care and lowering families' health care costs:

- The proportion of Latinos without health insurance plummeted from 31% to 17%, resulting in nearly 10 million Latinos gaining health coverage.
- The share of Latinos buying their own private insurance, including through the ACA marketplace, doubled, from 5% to 10%.
- In states that chose to expand Medicaid, the proportion of Latino adults under age 65 with Medicaid coverage nearly doubled, rising from 15% to 26%.

These gains matter. Considerable recent evidence shows the importance of health coverage to financial security, good health and the likelihood of survival. Nevertheless, much work remains to be done. For example, 17% of all Latinos were uninsured in 2024, more than three times the 5% of all non-Hispanic whites who were uninsured.

Rather than build on more than a decade of progress, the Trump administration and its congressional allies are threatening to erase the Latino community's hard-won gains in health care access and protection from unaffordable medical bills. Unprecedented federal attacks on American health care are under way, with harm particularly experienced in the Latino community:

- **The Trump administration is overseeing the largest loss of health coverage in American history.** According to the Congressional Budget Office (CBO), the number of uninsured Americans will grow by 8.7 million people from 2025 through 2028. This represents a 33% increase, more than double the largest past four-year rise, when the number of uninsured grew by 16% in the early 1990s. Unlike previous large spikes in the number of uninsured Americans, all of which were driven by economic downturns and losses of employer-based coverage, the Trump administration's much larger coverage loss is entirely self-inflicted, resulting from policy decisions made by the president and his congressional allies.
- **Two congressional decisions have cut more than \$1 trillion in federal support for Medicaid and ACA private insurance.** Over the next 10 years, the combination is projected to terminate health insurance coverage for approximately 14 million Americans, including more than 4 million Latinos.
 - In early July 2025, President Trump signed into law the so-called "One Big Beautiful Bill," which made the largest health care cuts in history. Many of those cuts singled out Latinos for disproportionate harm by increasing paperwork obstacles to program participation, deterring expansion of Medicaid eligibility in states like Florida and Texas and terminating eligibility for lawfully present immigrants.
 - Congress let ACA health care tax credits expire in January 2026. This decision raised average health insurance costs by \$1,000 a year for more than 20 million Americans, including 6.5 million Latinos who buy their own ACA insurance.

¹This report was authored by Stan Dorn, UnidosUS's Director of Health Policy.

²"Latino" and "Hispanic" are used interchangeably by the U.S. Census Bureau and throughout this document to identify persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican and Spanish descent; they may be of any race.

- **The Trump administration took significant actions, and threatened additional ones, that endangered Latinos' health.** Indiscriminate immigration enforcement, the attempted use of personal Medicaid records to help target immigration enforcement and proposed public charge regulations have combined to create a tremendous chilling effect. Many Latino families now avoid both health programs and health care settings, fearing that seeking coverage or care could lead to family members' deportation or prevent future improvements to immigration status. Within weeks of taking office, the administration terminated 90% of all funding for community organizations that help families navigate the complexities of health insurance and obtain coverage that meets their needs. And via regulation, the administration terminated ACA coverage for people awarded Deferred Action for Childhood Arrivals (DACA) status, who were brought to the United States as children and know no other home.

Other policies that would do great harm are also being advanced by federal officials. For the first time in history, the Trump administration is proposing immigration status limits for community health center services, treatment of severe mental illness and substance use disorders, and other programs funded by federal grants. If these proposals are enacted, millions of immigrants, including many who are lawfully present in the United States, will be denied all health care until their conditions worsen and require treatment in hospital emergency rooms.

The country's leaders must reverse these harmful policies and build guardrails to prevent their recurrence. But that will not be enough. **It will also be essential to reconstruct the country's health programs to do a much better job helping the families they serve.** Reconstruction should include four key components:

1. **A substantially more seamless and paperless health insurance system** that eliminates bureaucratic barriers that have long been used to deny health coverage to eligible people.
2. **Resources and accountability mechanisms that ensure high-quality customer service from the agencies that run health programs.** Significant investments in both technology and agency staff are needed to stop erroneous eligibility denials, prolonged processing delays and inaccessible websites and call centers. Agencies should live up to clear performance standards, enforceable in court by families who are harmed if those standards are violated.
3. **No more arbitrary denials of eligibility for people in need.** In states that refuse to expand Medicaid to cover poor adults, ACA coverage should be available, with additional assistance that makes care affordable to people who live in poverty.
4. **Health programs that meet the Latino community's distinctive needs.** Health care must be linguistically accessible and culturally attuned, supported by investments to develop a workforce that can achieve these important goals. People who contribute to their community but need assistance with health care should not be turned away because of immigration status. Recipients of federal funds (including state agencies) should be accountable in court if they pursue policies, such as a denial of linguistic access, that have the effect of discriminating based on race and ethnicity. And major investments will be needed to help Latino children and families recover from the profound trauma being caused by the current cruel and indiscriminate attacks on America's immigrants.

Between the ACA's 2010 enactment and 2024, Latino families' health coverage substantially improved, but further improvements are necessary

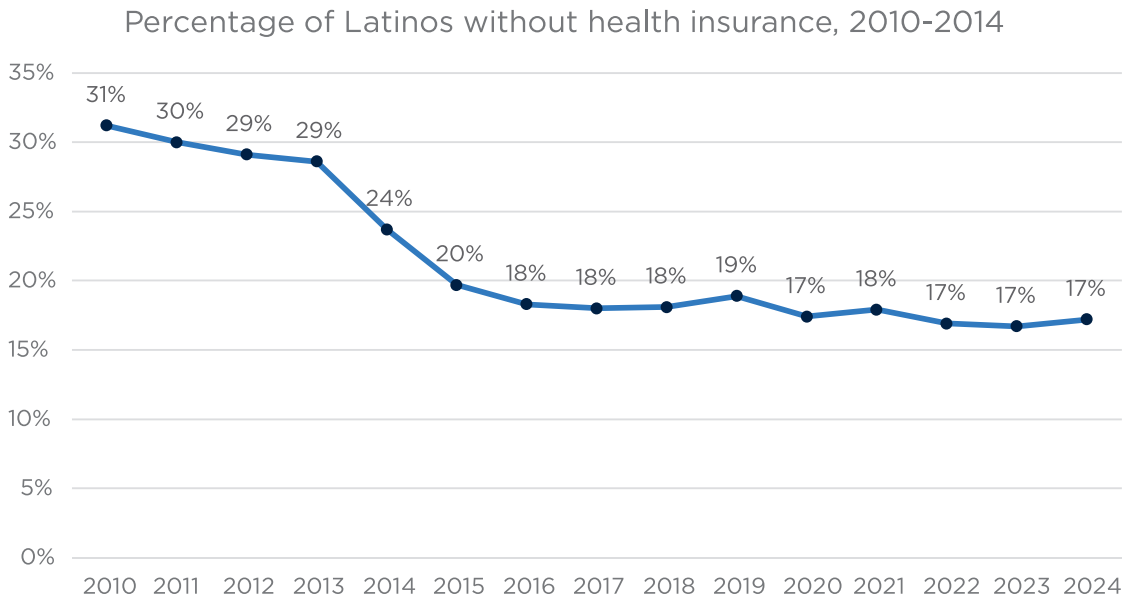
Following enactment of the Affordable Care Act (ACA) in 2010,³ and related policies implemented during the Biden administration,⁴ almost 10 million Latinos gained health insurance coverage. In 2010, nearly one-third of all Latinos (31%) lacked health coverage. Thanks to the ACA's expansion of Medicaid and the creation of tax credits people can use to buy their own private health insurance, that proportion plummeted to roughly 1 in 6 Latinos (17%) by 2024 (Figure 1).⁵

³ The ACA was signed into law in 2010, but many of the most important reforms took effect in 2014. Accordingly, some of the legislation's most dramatic results occurred in 2014 and later years, as shown in Figures 1-3.

⁴ Such related policies included enhanced premium tax credits, which were available from 2021 through 2025; increased funding for navigators to help people enroll and renew their coverage; and measures to limit administrative burdens imposed on people seeking to participate in health coverage programs.

⁵ If 31% of Latinos had been uninsured in 2024, rather than 17%, then 9.6 million additional Latinos would have been uninsured.

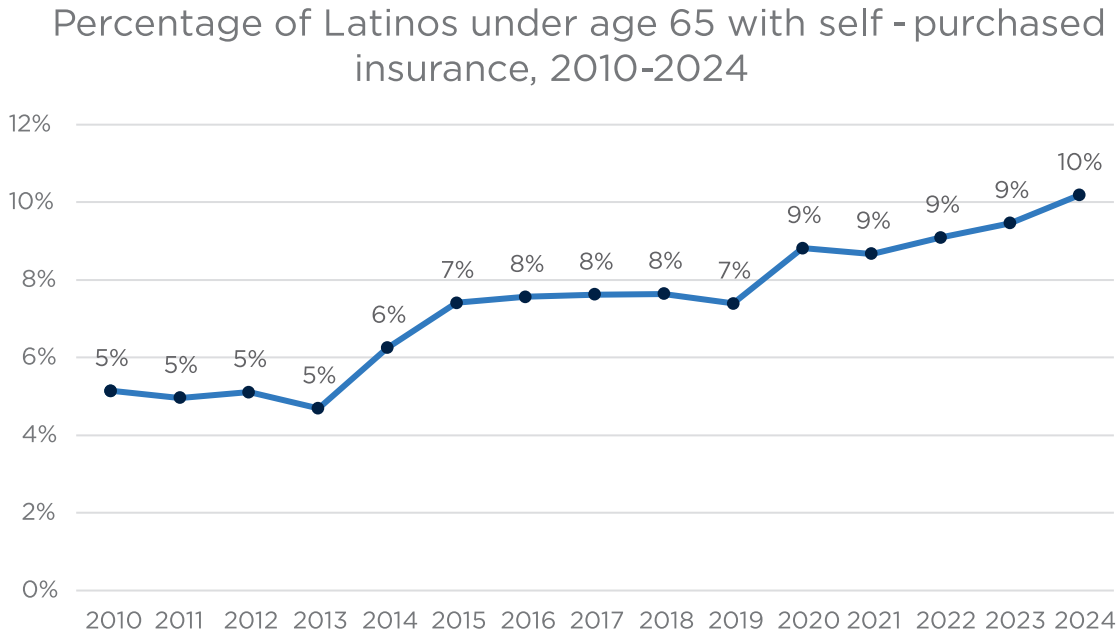
Figure 1. After the ACA passed in 2010, significantly fewer Latinos were left uninsured



Source: UnidosUS analysis of American Community Survey (ACS) data for 2010 to 2024, accessed via IPUMS, University of Minnesota, www.ipums.org (IPUMS).

Latinos made major coverage gains in two areas. First, the proportion of Latinos who bought their own insurance, including through ACA marketplaces, doubled, rising from 5% to 10% of all Latinos under age 65 (Figure 2). Second, in states that expanded Medicaid as allowed by the ACA, the percentage of adults under age 65 who received Medicaid coverage jumped from 16% to 26% (Figure 3).⁶

Figure 2. After the ACA passed in 2010, many more Latinos were able to buy their own health insurance

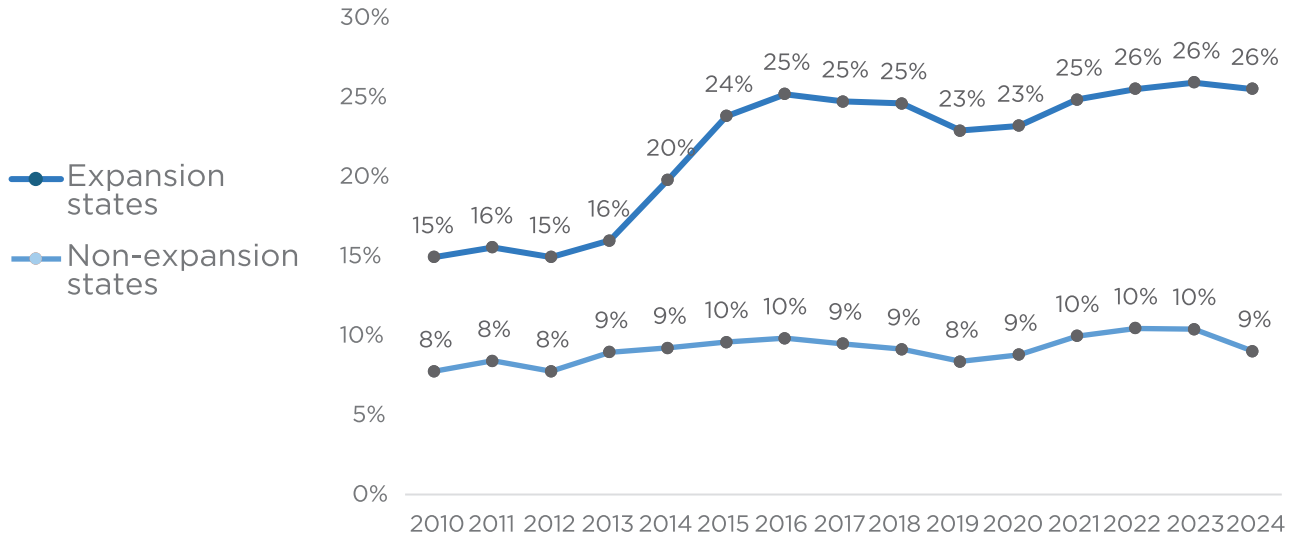


Source: UnidosUS analysis of ACS data for 2010-2024, accessed via IPUMS.

⁶ In non-expansion states, Medicaid coverage for such adults was largely unchanged, rising from 8% to 9% of all Latino adults under age 65.

Figure 3. After the ACA passed in 2010, Medicaid covered many more Latino adults — but only in states that expanded Medicaid

Percentage of Latinos age 19-64 covered through Medicaid, by state Medicaid expansion status: 2010-2024

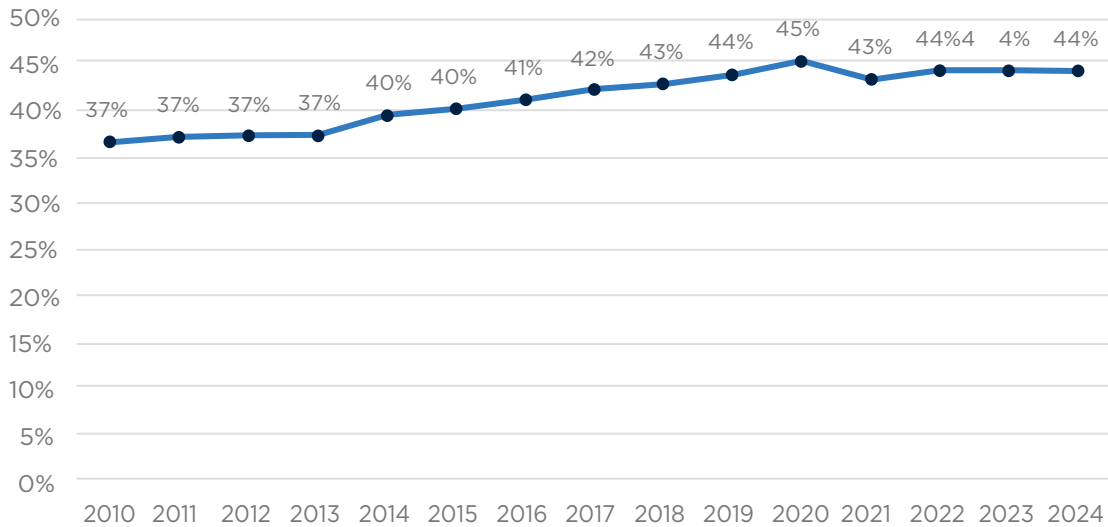


Source: UnidosUS analysis of ACS data for 2010-2024, accessed via IPUMS.
 Note: Medicaid expansion status, as shown in this figure, is based on coverage in 2024. Accordingly, the states classified as non-expansion states are Alabama, Florida, Georgia, Kansas, Kentucky, Mississippi, South Carolina, Tennessee, Texas, Wisconsin and Wyoming.

These gains in publicly facilitated coverage did not come at the expense of employer-sponsored insurance (ESI). The proportion of Latinos under age 65 covered through ESI rose from 37% in 2010, when the ACA passed, to 44% in 2024 (Figure 4).

Figure 4. After the ACA passed in 2010, ESI for Latinos grew stronger

The percentage of Latinos under age 65 enrolled in ESI: 2010-2024

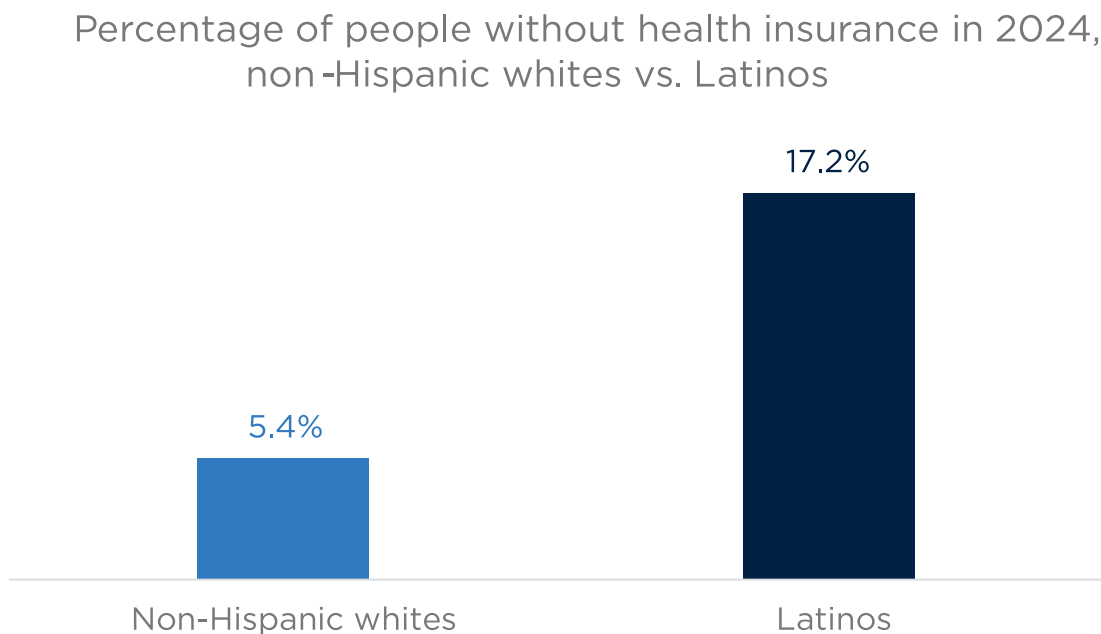


Source: UnidosUS analysis of ACS data for 2010-2024, accessed via IPUMS.
 Note: ESI = employer-sponsored insurance.

These coverage gains mattered. Since the ACA's enactment, a flood of research has shown the importance of insurance coverage to families' financial stability, health status and even survival.⁷

Notwithstanding these gains, in 2024, the percentage of people without health insurance was more than three times as high in the Latino community as among non-Hispanic whites at 17.2% vs. 5.4% (Figure 5).

Figure 5. Compared to non-Hispanic whites, Latinos were more than three times as likely to be uninsured in 2024



Source: UnidosUS analysis of ACS data for 2024, accessed via IPUMS.

Reflecting our country's long history of systemic racism and policy-driven inequities, many health disparities continued to harm the Latino community as the Biden administration drew to a close in late 2024. For example:

- Compared to 16% of non-Hispanic whites, 36% of Latinos had [no regular health care provider](#).
- A majority (55%) of Latino adults reported that it was [difficult to afford health care costs](#), in contrast to fewer than 40% of non-Hispanic whites.
- Compared to one-third of non-Hispanic whites (34%), [43% of Latinos postponed essential health care](#) or went entirely without it because of cost.
- In all, 36% of Latino immigrants with limited English proficiency (LEP) [reported](#) that their difficulty speaking or understanding English made it hard to get health care, and 27% said that their LEP made it challenging to apply for government help with food, housing and health care.
- Compared to 18% of non-Hispanic white women, 32% of pregnant Latinas [did not receive prenatal care in their first trimester](#).
- A large percentage (52%) of health care workers described [racism and discrimination in health care](#) as a major problem or crisis. In facilities that served mainly Latino patients, 61% reported observing racism or discrimination, compared to 43% in facilities that served mainly non-Hispanic white patients.
- Just one year after the Supreme Court's 2023 ruling prohibiting the consideration of race or ethnicity in college admissions, the number of Latino [medical students fell by more than 10%](#). The impact of ongoing shortages of Latino medical care professionals on the Hispanic community's health is likely to be considerable, especially given abundant evidence that, when clinicians and patients come from different backgrounds, communication, trust, patient adherence to recommendations and health outcomes can significantly worsen.

⁷ Thomas Buchmueller, et al., Improving Access to Affordable and Equitable Health Coverage: A Review from 2010 to 2024, ASPE Office of Health Policy Issue Brief HP-2024-11, June 7, 2024, <https://aspe.hhs.gov/sites/default/files/documents/b55406e87d3e3612024069b9ab44a9ab/improving-access-to-coverage.pdf>, accessed 3/25/26; Jennifer Tolbert, et al., Key Facts about the Uninsured Population, KFF, April 9, 2026, https://www.kff.org/uninsured/key-facts-about-the-uninsured-population/?utm_campaign=KFF-Uninsured&utm_medium=email&hsenc=p2ANqtz--L-acF7WTAIxRlxgH7z5ML-ATqMCXyGUvLYTWlsmGu51q_uYeDuWWuvk5KZwOzY-VjyC3wrWMhpmebfagwKMXJ53QXYw&hsmi=413021908&utm_content=413021908&utm_source=hs_email&entry=executive-summary-introduction.

By the end of 2024, it was clear that the journey toward health equity for Latino families was far from complete and more progress was needed. Unfortunately, the new national leadership that came to power in 2025 moved aggressively in the opposite direction.

Since January 2025, federal officials have mounted a fierce attack on American health care, doing particular damage to Latino families

The Trump administration is presiding over the greatest loss of health insurance in American history

In February 2026, non-partisan experts at the Congressional Budget Office (CBO) released updated economic and budgetary forecasts that incorporated the effects of Trump administration policies and enacted legislation. [CBO now projects that](#), over the four years of the Trump administration, the number of uninsured Americans will grow by 8.7 million people — a 33% increase. This will be by far the largest four-year loss of American health insurance since 1987, when the Census Bureau first began reporting reliable survey results showing the number of people without health insurance.⁸

During the early 1990s, the early 2000s and the late 2000s, the number of uninsured Americans increased by more than 10% over various four-year periods. None these major losses came close to the losses forecast by CBO for President Trump’s second term (Table 1):

- The 33% increase in the number of uninsured Americans projected by CBO for the Trump administration is more than twice the size of the largest previous four-year increase recorded in Census Bureau data: a 16% increase from 1989 to 1992.
- In numerical terms, the 8.7 million people projected to lose coverage from 2025 through 2028 far exceeds the largest previous loss, when 5.9 million people lost coverage from 2007 to 2010.

Table 1. Past four-year increases in the number of uninsured that exceeded 10%, 1987-2024, compared to CBO projections for 2025 through 2028

Period of increase	Overlapping recession?	Increase in the number of uninsured people	
		Millions	Percentage
1989-1992	Yes: 1990-1991	5.3	16%
1990-1993	Yes: 1990-1991	5.0	14%
1991-1994	Yes: 1990-1991	4.3	12%
2000-2003	Yes: 2001	5.0	13%
2007-2010	Yes: 2007-2009	5.9	13%
2025-2028 (CBO projection)	No⁹	8.7	33%

Source: UnidosUS analysis of U.S. Census Bureau, "Table HIB-1. Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 1999 to 2012," in [Health Insurance Historical Tables - HIR Series](#); Table C-1, Health Insurance Coverage: 1987 to 2007, in Carmen DeNavas-Walt, et al., [Income, Poverty, and Health Insurance Coverage in the United States: 2007](#) (U.S. Census Bureau Aug. 2008); Census Bureau, [Table HIC-4 ACS](#), Health Insurance Coverage Status and Type of Coverage by State -- All Persons: 2008 to 2024." Health Insurance Historical Tables - HHI Series, Page Last Revised - August 12, 2025; CBO, ["Federal Subsidies for Health Insurance."](#) Baseline Projections, February 2026; and National Bureau of Economic Research, [US Business Cycle Expansions and Contractions](#).

Note: Increases are relative to the first year of each four-year period. For example, the number of uninsured people increased from 1989 to 1992 by 5.3 million people. That rise represented a 16% increase over 1989 levels. Detailed year-by-year numbers from 1987 through 2024 are available upon request.

⁸ The Census Bureau’s published data tables showing the number of uninsured people go back to [1987, when the Current Population Survey Annual Social and Economic Supplement \(CPS-ASEC\) time series began](#). Before then, CPS estimates of the number of people without health insurance [suffered from significant limitations](#).

⁹ CBO projects that average annual unemployment will rise by 0.3 percentage points in 2026, followed by a drop of 0.1 percentage points in 2027 and no change in 2028 (CBO, [Economic Projections](#), February 2026). The health coverage losses projected by CBO are not the result of anticipated economic declines remotely comparable to those during major health insurance losses, when unemployment rose by 2.2 percentage points from 1989 to 1992; by 2.0 percentage points from 2000 to 2003; and by 5.0 percentage points from 2007 to 2010. U.S. Bureau of Labor Statistics, [Employment status of the civilian noninstitutional population](#), 1950s to date. In fact, CBO projections show an increasing proportion of Americans receiving ESI every year from 2025 to 2028. By contrast, during each past four-year period where the number of uninsured people grew by 10% or more, the percentage of people covered through employer plans fell either every year or in all years but one, according to the Census Bureau data cited above.

In the past, all coverage losses of 10% or more overlapped with recessions, when millions of people were laid off and lost employer-based insurance. By contrast, the much larger losses happening under President Trump are resulting from policy choices, without major economic downturns. These losses are unprecedented, both because they are the largest in history and because the damage is entirely self-inflicted.

Congressional decisions have caused significant harm

Two choices by the congressional majority have caused tremendous harm to health care for Latinos and other Americans: the passage of a mega-budget bill that cut basic needs programs to fund immigration enforcement and tax breaks that primarily benefit the wealthy, and the decision to let enhanced premium tax credits (EPTCs) expire in January 2026. Together, these decisions are projected to cause enormous health coverage losses for Americans, with particularly grievous losses experienced by Latinos and people in other historically marginalized communities.

The so-called “One Big Beautiful Bill”

The ‘One Big Beautiful Bill Act’ (OBBBA), passed by the congressional majority and signed into law by President Trump on July 4, 2025, cut Medicaid and ACA health coverage by more than \$1 trillion — the largest health care cuts in American history. These cuts fell into four major categories:

1. Increases in red tape and paperwork preventing millions of people from securing health coverage despite their eligibility.

- Low-income adults who qualify for Medicaid under the ACA’s eligibility expansion must submit paperwork documenting compliance with or exemption from work requirements. When states implemented similar policies in the past, [more than 90% of people terminated from Medicaid](#) were actually working or exempt from work requirements due to chronic health problems or caretaking responsibilities. Similar bureaucratic barriers will take a toll on hardworking families across America.
- Those same low-income adults must recertify their continued eligibility every six months. In the past, [roughly 7 in 10 people terminated from Medicaid at redetermination following the expiration of COVID-era safeguards lost their health coverage because of nothing more than missing or misplaced paperwork](#), with particularly serious harm sustained by people from historically marginalized communities, as explained below.
- These measures are expected to terminate Medicaid for 8 million adults, or 43% of all adults who qualify for Medicaid expansion, [according to Urban Institute researchers](#).¹⁰
- People who benefit from advance payment of ACA tax credits will now risk incurring thousands of dollars in federal tax penalties if those advance payments inadvertently exceed their premium tax credit (PTC) amounts as shown on income tax returns filed the following year. Among other implications, this increases paperwork burdens, since failing to let ACA marketplaces know about all relevant changes to household circumstances during the year could lead to significant federal tax penalties the following year.

2. Cost shifts from the federal government to states that will lead many states to significantly cut benefits, enrollment or provider payments.

The legislation limited states’ authority to raise their share of Medicaid funds by taxing insurance companies, hospitals and nursing homes. This denied states both the money raised through these taxes and the matching federal funds the state revenue generated. Because states are legally required to balance their budgets, the fiscal losses resulting from federal legislation require offsetting increases to state taxes or cuts to Medicaid and other state programs.¹¹

3. Disincentives for states to expand Medicaid.

With 11 states still refusing to expand Medicaid to cover low-wage, working adults, OBBBA created two new disincentives to expansion:

- States will now receive less federal funding to cover expansion costs. The bill repeals incentive payments that heightened funding levels for the first few years of Medicaid expansion. It also substantially cuts the percentage of federal funds paying for emergency services used by adults who would otherwise qualify for expanded coverage if not for their immigration status. Moreover, the above-noted limits on states’ authority to raise taxes on insurers and providers are significantly harsher for states that expand Medicaid, thus giving states more disincentives to expand.
- Hospitals, which have been powerful advocates of Medicaid expansion in many states, will receive much less increased revenue from expansion. The above-noted paperwork burdens will reduce the number of expansion adults who obtain health coverage, thus limiting hospitals’ reimbursement

¹⁰ These estimates are for a scenario in which states engage in moderate mitigation measures to limit coverage losses. If states engage in high mitigation measures, 4.9 million are estimated to lose coverage, representing a 27% decline. If states engage in low mitigation efforts, 10.1 million are estimated to lose coverage, representing a 55% drop.

¹¹ OBBBA creates additional state fiscal pressures through state income tax changes that automatically incorporate changes to federal income tax law and major shifts of federal costs to states involving the Supplemental Nutrition Assistance Program (SNAP).

gains. In addition, the bill imposes particularly onerous limits on “retroactive eligibility” in Medicaid expansion states. This eligibility lets hospitals receive payments for care provided to eligible patients who have not yet completed the paperwork needed to enroll in Medicaid. The bill also changed the rules for special state payments to hospitals, imposing limits that are stricter in Medicaid expansion states and thereby creating even more revenue losses for hospitals.

- 4. Termination of eligibility for lawfully present immigrants.** Across all health coverage programs — Medicare, Medicaid, ACA coverage, the Basic Health Program and the Children’s Health Insurance Program — the legislation terminates eligibility for lawfully present immigrants who are not green-card holders, Cuban or Haitian entrants, or citizens of countries in Micronesia who, by treaty, have a right to work in the United States. The people losing health care include refugees and people fleeing persecution or domestic violence in their home countries. The bill also terminates ACA coverage for green-card holders with incomes below the federal poverty level whose immigration status makes them ineligible for Medicaid, most often because their approved immigration status began less than five years ago.

The expiration of ACA health tax credits

From 2021 through 2025, premium tax credits (PTCs) that working families use to buy their own health insurance in the ACA marketplace were enhanced to provide more assistance and help additional people. As a result, consumer costs fell and enrollment greatly increased.

These enhanced premium tax credits (EPTCs) were set to automatically expire on January 1, 2026, along with other provisions in the tax code that primarily benefited the extremely wealthy. In OBBBA, Congress made the latter permanent but let the former expire. Later in 2025, Democrats sought to extend EPTCs and obtained some Republican support but not [enough to exceed the 60-vote threshold](#) that is required for most legislation to pass the Senate. As a result, EPTCs expired.

Without EPTCs, premium costs for families’ prior coverage rose by [\\$1,000, on average](#), for [more than 20 million people](#) who relied on EPTCs to purchase health coverage in 2025, [including 6.5 million Latinos](#). Fully [1 in 10 previous ACA enrollees immediately dropped their coverage](#), in response to higher premium costs and became uninsured. By the end of 2026, a total of 4 to 7 million people are projected to lose their ACA insurance.¹² [Among those who remain in the ACA marketplace](#), 80% are experiencing higher health costs, including 51% who report that their health care costs are “a lot higher.” More than half of ACA enrollees who are keeping their coverage are cutting back on food and other essentials to compensate for rising health care costs.

The impact of these two congressional choices? Based simply on their current program participation, Latinos and members of other historically marginalized communities will disproportionately suffer coverage losses. That is because they are particularly likely to need and qualify for Medicaid and ACA coverage, since they frequently work in low-wage jobs that do not offer health benefits. Thus, Latinos are among the people who would experience disproportionate harm from the so-called “One Big Beautiful Bill” and the expiration of EPTCs, even if beneficiaries of all races and ethnicities were equally likely to be terminated.

To estimate coverage losses by race and ethnicity, we began with [KFF’s](#) apportionment by state and health program of the 14.3 million people whom CBO projects will become uninsured within 10 years following OBBBA’s enactment and the expiration of EPTCs. Based on the current distribution of enrollment in each state and health program as shown by the most recent available Census Bureau data, we estimated the race and ethnicity of people becoming uninsured in each category.

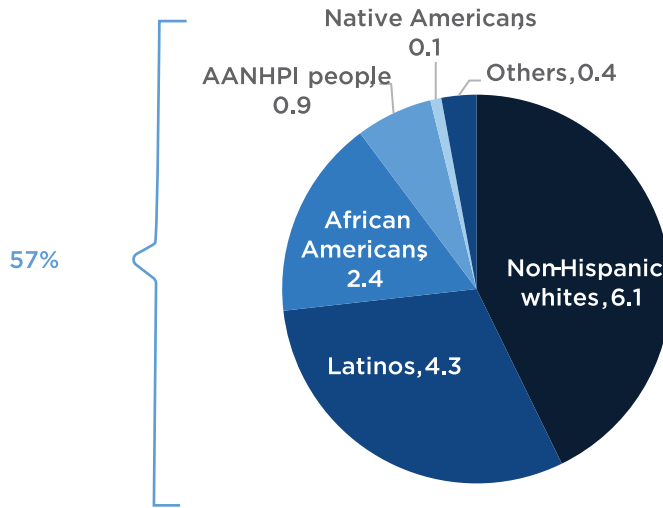
Basing estimated coverage losses on current enrollment patterns, people from all backgrounds would suffer terrible coverage losses. But, nationally, 57% of people estimated to become uninsured would be people of color, including (Figure 6):

- 4.3 million Latinos
- 2.4 million African Americans
- Nearly 1 million Asian Americans, Native Hawaiians and Pacific Islanders (AANHPI)
- More than 100,000 Native Americans

¹² Actuaries at [Wakely Consulting](#), based on information about consumers who did not pay 2026 premiums and thus were terminated from Marketplace coverage after the completion of open enrollment, estimate that average monthly enrollment is likely to drop by between 17% to 26%. That would mean a total decline of 4.3 to 6.6 million people, relative to the 25.4 million people who purchased marketplace coverage during the average month in 2025, according to the baseline CBO estimates used by Wakely.

Figure 6. Even if beneficiaries of all races and ethnicities were equally likely to become uninsured, people of color would suffer disproportionate harm

Newly uninsured due to OBBBA and the expiration of EPTCs, distributed by race and ethnicity in proportion to current enrollment (millions)



Source: UnidosUS analysis of data from March 2025 Current Population Survey (CPS), accessed via IPUMS, and coverage loss estimates from [KFF 2025](#).
 Notes: These estimates take KFF’s projected insurance losses by state and program (Medicaid, ACA health coverage and Medicare) and distribute them based on the race and ethnicity of program participants in each state in March 2025. For Medicaid and ACA health coverage, the analysis is limited to beneficiaries under age 65, since those age 65 or older are likely to have access to Medicare and thus unlikely to become completely uninsured. Enrollment in ACA health coverage in 2025 is based on self-reported enrollment into subsidized marketplace plans. Latinos are Hispanics of all races. All other categories are limited to non-Hispanics. AANHPI=Asian Americans, Native Hawaiians and Pacific Islanders. “Other” includes people of multiple races.

Estimates for all 50 states and the District of Columbia are in Appendix Tables 1 and 2. In some states, Latinos loom especially large among those projected to lose coverage. In eight states — Florida, New Mexico, California, Texas, Arizona, Colorado, Nevada and New Jersey — Latinos comprise 40% or more of everyone estimated to become uninsured (Table 2, below). In another group of eight states — California, Florida, Texas, New York, Arizona, New Jersey, Illinois and Washington — more than 100,000 Latinos are estimated to lose coverage (Table 3, below).

Table 2. States where Latinos comprise 40% or more of all people estimated to become uninsured

Rank	State	Estimated share of newly uninsured who are Latino
1	Florida	58%
2	New Mexico	56%
3	California	53%
4	Texas	48%
5	Arizona	45%
6	Colorado	45%
7	Nevada	42%
8	New Jersey	40%

Source: UnidosUS analysis of data from March 2025 CPS, accessed via IPUMS, and coverage loss estimates from [KFF 2025](#).
 Notes: These estimates take KFF’s projected insurance losses by state and program (Medicaid, ACA health coverage and Medicare) and distribute them based on the race and ethnicity of program participants in each state in March 2025. For Medicaid and ACA health coverage, the analysis is limited to beneficiaries under age 65, since those age 65 or older are likely to have access to Medicare and thus unlikely to become completely uninsured. Enrollment in ACA health coverage in 2025 is based on self-reported enrollment into subsidized marketplace plans. Latinos are Hispanics of all races.

Table 3. States where more than 100,000 Latinos are estimated to become uninsured

Rank	State	Estimated number of newly uninsured Latinos
1	California	917,000
2	Florida	858,000
3	Texas	683,000
4	New York	260,000
5	Arizona	190,000
6	New Jersey	156,000
7	Illinois	151,000
8	Washington	129,000

Source: UnidosUS analysis of March 2025 CPS data, accessed via IPUMS, and coverage loss estimates from [KFF 2025](#).
Notes: These estimates take KFF's projected insurance losses by state and program (Medicaid, ACA health coverage and Medicare) and distribute them based on the race and ethnicity of program participants in each state in March 2025. For Medicaid and ACA health coverage, the analysis is limited to beneficiaries under age 65, since those age 65 or older are likely to have access to Medicare and thus unlikely to become completely uninsured. Enrollment in ACA health coverage in 2025 is based on self-reported enrollment into subsidized marketplace plans. Latinos are Hispanics of all races.

In actuality, Latinos and members of other historically marginalized communities are likely to experience much greater losses than those estimated above. That is because those estimates assume that Medicaid beneficiaries of all races and ethnicities will be equally likely to lose coverage. In fact, coverage loss is especially likely for Medicaid beneficiaries who are Latinos or from other marginalized communities, for three reasons:

- 1. Many of the OBBBA cuts terminate health insurance when overburdened and under-resourced families are unable to cope with new and challenging administrative burdens.** People from marginalized communities are particularly likely to fall prey to administrative burdens, for many reasons: more frequent address changes that prevent families from receiving state notices; limited English proficiency and limited literacy that make it hard to understand state notices, which are often written in complex prose; limited broadband access and internet fluency, which makes it hard to renew coverage online; and low-wage jobs that do not allow, during business hours, visits to social services offices or prolonged waits on the phone while trying to reach a call center.

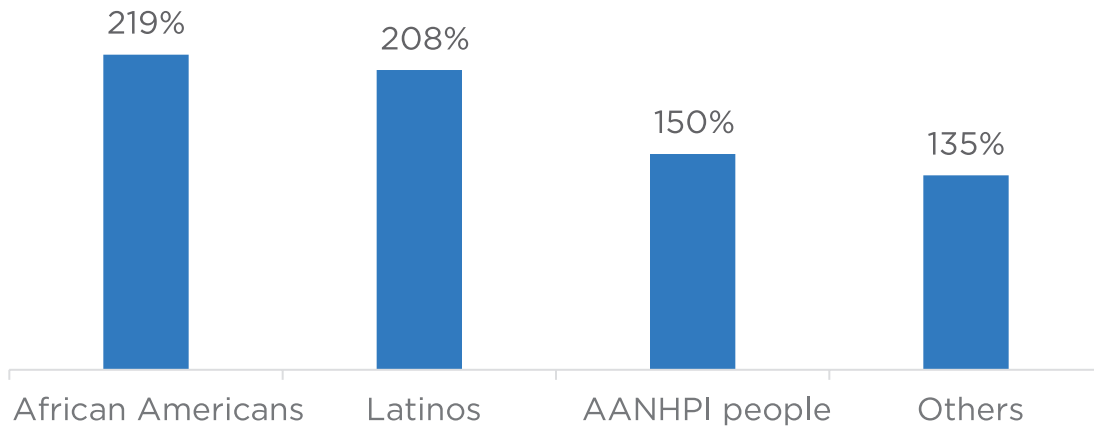
As a result of these and other factors, people from marginalized communities were especially likely to be terminated from Medicaid during the [“great Medicaid unwinding,”](#) when roughly 90 million¹³ Medicaid beneficiaries had their eligibility redetermined following the expiration of pandemic-era coverage guarantees. As noted earlier, roughly 70% of the people who were terminated from Medicaid lost coverage because of nothing more than missing paperwork or other administrative factors. Compared to non-Hispanic white beneficiaries (Figure 7):

- Latinos and African Americans were more than twice as likely to be unable to complete the redetermination process.
- AANHPI people were 50% more likely to be unable to complete the redetermination process.

¹³ [Medicaid covered 87.4 million people at the program's enrollment peak](#). Adding enrollees in the Children's Health Insurance Program (CHIP), 94.6 million were covered. All of the former had eligibility redetermined, but only some of those covered through CHIP were subject to redetermination during unwinding.

Figure 7. During Medicaid unwinding, when roughly 90 million people had their eligibility redetermined, administrative burdens took a particularly heavy toll in communities of color

Likelihood of Medicaid beneficiaries being unable to complete the redetermination process during unwinding, relative to non-Hispanic whites, by race and ethnicity



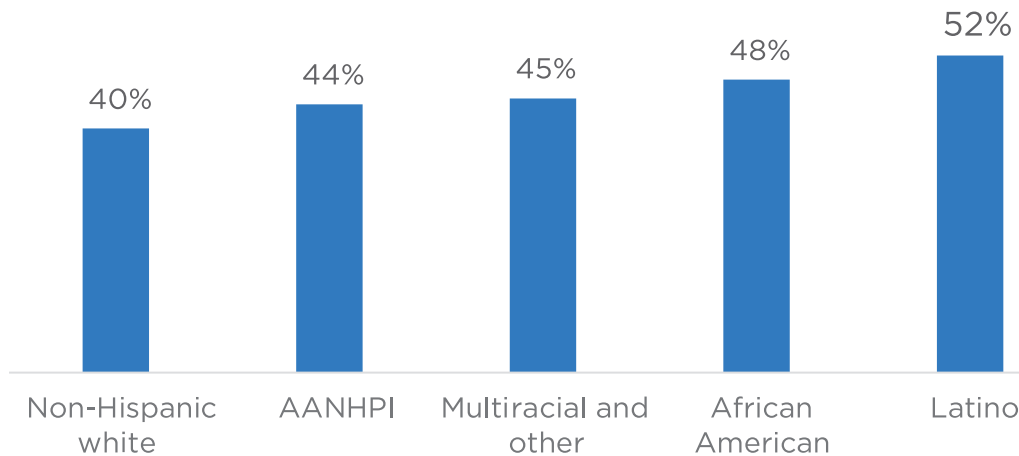
Source: Rumalla, et al., *JAMA Intern Med.* 2024.

Notes: Latinos are Hispanics of all races. All other groups are limited to non-Hispanics. AANHPI=Asian Americans, Native Hawaiians and Pacific Islanders.

That same pattern applies even outside the Medicaid unwinding context. At regular Medicaid redeterminations, a very high percentage of people who are terminated are in fact eligible. That percentage is particularly high for Latinos. More than half of Latinos terminated from Medicaid (52%) lose coverage despite remaining eligible, compared to 40% of non-Hispanic white beneficiaries (Figure 8).

Figure 8. When Medicaid eligibility is being redetermined, the administrative burdens are so heavy for Latinos that more than half of people terminated are actually eligible

Among beneficiaries terminated from Medicaid during regular redetermination, the percentage who remain eligible, by race and ethnicity



Source: HHS Assistant Secretary for Planning and Evaluation, 2022, analysis of March 2015–November 2016 data from Survey of Income and Program Participation.¹⁴

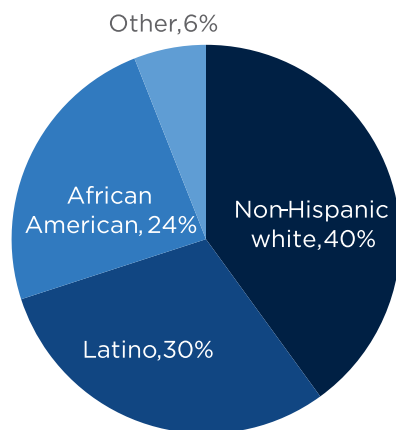
Notes: Latinos are Hispanics of all races. All other groups are limited to non-Hispanics. AANHPI = Asian American, Native Hawaiian and Pacific Islander.

¹⁴ HHS Assistant Secretary for Planning and Evaluation, Office of Health Policy, Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches, Issue Brief, Aug. 19, 2022, downloaded on 4/5/26 from <https://aspe.hhs.gov/sites/default/files/documents/dc73e82abf7fc26b6a8e5cc52ae42d48/aspe-end-mcaid-continuous-coverage.pdf>.

2. **The legislation’s provisions to discourage Medicaid expansion will take a disproportionate toll on Latinos and African Americans.** With Florida and Texas among the 11 states that continue to refuse expansion, 60% of those who are uninsured as a result are from communities of color, including 30% who are Latinos (Figure 9).

Figure 9. State refusals to expand Medicaid disproportionately harm Latinos and other people from historically marginalized communities

Uninsured adults in non-expansion states who are ineligible for both Medicaid and Marketplace coverage, by race and ethnicity: 2023



Source: [KFF 2025](#).

Note: Latinos are Hispanics of all races. All other groups are limited to non-Hispanics.

3. **The bill’s termination of health coverage for lawfully present immigrants has a disproportionate impact on Latinos as well as people from the AANHPI community.** Non-citizens comprised 16% of all Latino Medicaid enrollees in 2024 and 19% of AANHPI Medicaid enrollees, compared to just 2% of non-Hispanic whites covered by Medicaid.¹⁵ But these eligibility limits are only one part of a broader assault on health care for America’s immigrants.

Administrative actions have caused serious harm, especially to the Latino community

Many attacks are focused specifically on immigrants

Consistent with the broader anti-immigrant agenda being pursued by the Trump administration, health care for immigrants has come under fierce assault, in several ways.

First, Trump administration actions have created a chilling effect that deters Latino families from seeking health coverage and care. Many families fear that obtaining health care or participating in programs like Medicaid could lead to family members being arrested for immigration violations or being denied future improvements in immigration status. Between 2023 and 2025, the proportion of immigrant parents reporting that their [families stopped participating in public programs because of immigration-related concerns nearly doubled](#), rising from 11% to 18%. [In geographic areas where adults report U.S. Immigration and Customs Enforcement \(ICE\) activities, 24% of immigrant families avoid Medicaid](#) and other programs that provide non-cash benefits. In all geographic areas, 22% of mixed-status families, most of whom include both immigrant adults and citizen children, avoid Medicaid and other programs, fearing that participation could lead to family members being targeted for immigration enforcement or denied future improvements to immigration status. And in terms of seeking health care, [one-third of uninsured, immigrant adults \(32%\) went without or delayed essential health care](#) in 2025 because of concerns about a family member’s immigration status.

This profound chilling effect results from multiple administration policies and practices:

¹⁵ UnidosUS analysis of 2024 ACS data, accessed through [IPUMS](#).

- Indiscriminate immigration enforcement has created reasonable fears of arrest, confinement in terrible conditions, and deportation of immigrants and their family members who are long-term, law-abiding residents, legally present in the United States or even U.S. citizens. [Half of immigrant adults](#) report that they are “somewhat concerned” or “very concerned” about health officials or health care providers sharing confidential information with ICE or Customs and Border Protection.
- New administration policies about “sensitive locations” mean that health care settings are no longer off-limits for immigration enforcement. Going to the doctor or even seeking emergency hospital care can risk arrest, confinement and potential deportation.
- The administration has repeatedly attempted to share confidential data from Medicaid program records with ICE to help with immigration enforcement. Despite litigation seeking to stop this practice, significant privacy breaches have already taken place, making public program participation a risk factor triggering potential ICE assaults.
- The administration has proposed [new “public charge” regulations](#) that, if finalized, could prevent immigrants from obtaining green cards or otherwise improving their immigration status if family members have obtained health coverage from Medicaid, the Children’s Health Insurance Program or ACA insurance.

Second, the Trump administration has proposed immigration status restrictions on community health centers, programs that treat severe mental illness and substance use disorders, and other sources of care funded through federal grants. No such limits have ever applied to these health care programs in the past, under either Republican or Democratic administrations, including the first Trump administration. If these new and unprecedented proposals are enacted, millions of immigrants would be denied health care until their conditions worsen and treatment is needed in hospital emergency rooms, the most expensive health care setting. [Almost 40% of community health centers’ 32 million patients are Latino](#) and [40% of all Latino immigrants use health centers as their usual source of care](#), so the threat to the Latino community is enormous.

Third, President Trump’s executive orders reject the need for federal health programs to address the needs created by American diversity. For example, President Trump [declared](#) English “the official language of the United States,” revoking past executive orders that sought to improve access to services for people with limited English proficiency. In implementing this new order, the Department of Justice [abandoned past prohibitions of policies that have disparate impact](#) based on people’s race or national origin, instead requiring proof of discriminatory intent, which is often impossible to find. Executive orders also required the elimination of federal offices and programs that promote diversity, equity and inclusion (DEI); terminated equity-related grants and contracts; required federal contractors to certify that they do not operate DEI programs; and limited what public and private entities can do to ensure equal access to education.

Fourth, the Trump administration promulgated regulations [terminating DACA holders’ eligibility for ACA health coverage](#). Brought to the United States as children, these “American dreamers” know no other home.

Other attacks would harm Americans from all backgrounds, with Latinos experiencing disproportionate harm

The Trump administration has taken other steps to raise costs and limit coverage for millions of people in need, including Latinos. For example:

- Within days of President Trump taking office, the administration cut health care navigator grants by 90%. As a result, organizations rooted in local communities lost essential resources required to help families both understand their options and take the steps needed to retain or obtain health coverage. Given the disproportionate impact of administrative burdens on Latinos, the withdrawal of assistance in coping with those burdens is likely to severely dampen health care enrollment in Hispanic communities.
- The administration has proposed two omnibus sets of regulations for ACA health coverage, one to take effect in 2026 and the other in 2027. Each set would significantly increase consumer costs and reduce coverage by imposing major new paperwork burdens for people seeking to enroll or renew their insurance.¹⁶ The first set of regulations was finalized largely as proposed, but most of its provisions were [stopped in court](#). The second set was proposed but has not yet been finalized. With [6.5 million Latinos](#) relying on ACA health coverage, the damage wrought by these rules would have a particularly severe impact in Hispanic communities.
- The administration is [targeting several states run by Democratic governors for unprecedented financial sanctions](#) based on unsubstantiated claims of widespread Medicaid fraud. This assault began in Minnesota, where the administration deferred payment of \$260 million for past services and proposed to deny \$2 billion per year in payments going forward. Federal officials have sent letters to California,

¹⁶ For a comprehensive analysis of both rules, see the series of posts in Health Affairs Forefront by Georgetown University Professor Katie Keith on [February 17, 2026](#); [February 13, 2026](#); [February 11, 2026](#); [August 22, 2025](#); [June 27, 2025](#); and [June 23, 2025](#).

Maine and New York signaling the start of similar attacks. [With 7.2 million Latino Medicaid beneficiaries in California and New York alone](#), Hispanic communities will experience great harm if the administration succeeds in using the pretext of fraud to deny state Medicaid programs the resources they need to serve eligible families. Since states are legally required to balance their budgets, massive cuts in federal Medicaid funding could lead states to create or lengthen waiting lists, stop covering essential services, cut payments to health care providers or terminate previously eligible people.

The path forward: reversing recent attacks and reconstructing America's health care programs

As an essential first step, Congress must repeal health care provisions in the so-called “One Big Beautiful Bill,” restore EPTCs, reverse administration policies that endanger Latino families’ health and well-being and erect guardrails to prevent similar actions in the future.¹⁷ But that is not enough. It will also be essential to reconstruct the country’s health care programs to fully and fairly meet the needs of Latinos and other Americans who live in historically marginalized communities.

Such reconstruction has four core elements:

- 1. Making health programs much more seamless and paperless for overburdened, under-resourced families.** Eligibility should be redefined so that people automatically qualify for a minimum level of assistance based on prior-year tax returns, making it unnecessary for families to provide paperwork showing low income.¹⁸ In each state, a single system should determine eligibility for all health programs, so families seeking health coverage aren’t bounced from one government agency to another.¹⁹ And when a government agency administering a need-based, non-health program has already found that a family has income low enough to qualify for Medicaid, the family should be enrolled without waiting for the Medicaid agency to address the questions that another government agency has already resolved.²⁰
- 2. Ensuring high-quality customer service by providing the agencies that run health programs with essential resources and holding them accountable to the families they serve.** Medicaid agencies and ACA marketplaces need resources to run effective websites, call centers and social service offices. Making accurate eligibility determinations relies on a strong and updated data infrastructure, as evident during Medicaid unwinding, when numerous eligible children were terminated due to archaic state eligibility systems. Without adequate agency staff, families can face unmanageable delays in getting help over the phone or in person. The resources needed to overcome those challenges should be accompanied by legal requirements to limit procedural denials and terminations to specified levels. Those requirements should include targets for basing eligibility on data accessible to the government, rather than requiring needless paperwork from families. And if families are harmed by an agency’s failure to meet those standards or other consumer-protection safeguards, families should have the right to seek judicial relief requiring legal compliance. The latter step is essential to ensure that the promises embedded in federal statute are kept, even in times when federal agencies lack the resources or will needed to vindicate families’ rights.
- 3. Ending arbitrary denials of eligibility for people in need.** In states that refuse to expand Medicaid to cover poor adults, ACA coverage should be immediately available, with additional assistance that makes care affordable to people who live in poverty.²¹

¹⁷ One lesson learned from recent events is that even administrative policies that have been in place for decades can be repealed or revised. Incorporating such policies in statute would protect them from similar future attacks.

¹⁸ A similar approach is used to determine eligibility for federal assistance for post-secondary education and to means-test premiums for Medicare Parts B and D. Families are guaranteed a minimum level of assistance, based on prior-year tax returns, but may apply for additional help if their circumstances change. Using income tax returns to qualify people for health coverage could be very powerful, both in reaching the eligible uninsured and in renewing beneficiaries’ coverage. In all, 80% of people without health insurance in 2025 filed or were included as dependents on federal income tax returns, including 82% of uninsured Latinos; and 70% of people enrolled in Medicaid in 2025 filed or were included as dependents on federal income tax returns, including 75% of Latino Medicaid beneficiaries. (UnidosUS analysis of March CPS data for 2025, accessed via [IPUMS](#).)

¹⁹ The states that have continuously operated their own marketplaces since ACA coverage began in 2014 use a single system to determine eligibility for all programs. As a result, someone who applied for or previously received coverage through one program is automatically shifted to a different program, without any need to complete paperwork, if their income qualifies them for a different program. Under the proposal in the text, each state would be required to either operate such an integrated, cross-program eligibility system or agree to have each program grant eligibility based on the findings of other programs that also serve state residents. The latter approach is used today in so-called “determination states,” which qualify people for Medicaid if the Marketplace has found that their income is too low for PTCs but appropriate for Medicaid. [Past research](#) found that eligible people were much less likely to be uninsured in states with integrated eligibility systems.

²⁰ This approach would disregard the technical differences between how programs define household size and countable income. Simply granting Medicaid to people already found eligible by SNAP, for example, could eliminate vast amounts of paperwork. More than 40% of Medicaid beneficiaries, including 43% of Latinos covered by Medicaid, participated in SNAP in 2024; renewal could thus be made paperless for a huge proportion of Medicaid beneficiaries, based on this single step. And more than 4 million uninsured people (including 2 million uninsured Latinos) participated in SNAP in 2024. They were already determined to have low income and to be either citizens or lawful permanent residents, so their automatic qualification for—and enrollment in—Medicaid could enable significant progress enrolling uninsured people who qualify for coverage. (UnidosUS analysis of 2024 ACS data, accessed via [IPUMS](#).)

²¹ In theory, policymakers could develop a new, federally administered Medicaid program to serve such uninsured adults, after an initial period of ACA coverage. In practice, a daunting amount of work may be needed to set up and operate such a specialized Medicaid program.

4. Meeting the Latino community's distinctive health care needs:

- Health programs should not deny eligibility based on immigration status when people are lawfully present, living in the United States with the government's knowledge and permission. The overwhelming majority of immigrants work hard, pay taxes and contribute to their communities. If they require health care coverage, lawfully present immigrants should be treated the same way as anyone else in need.
- States and localities should have the option of using their own resources, in some cases with federal matching funds, to cover all residents who need assistance, regardless of immigration status.²²
- Eligible people should be able to enroll in health programs and other public programs without that participation being used to prevent future improvements in immigration status.²³
- Federal statutes should codify the previous "sensitive locations" policy, which prohibits immigration enforcement at health care sites (as well as schools, places of worship, and certain other locations).
- Strong data security and privacy protections—supported by personal civil and criminal liability for officials who share data improperly—are essential for Latinos to feel confident that seeking health coverage or other benefits will not place immigration enforcement targets on their backs.
- When recipients of federal funding implement policies that have a discriminatory impact on Latinos or other historically marginalized groups, people who are harmed should be empowered to go to court and seek a change in policy. That would let local Latino communities address such problems as a Medicaid program that does not make its services fully accessible to people with limited English proficiency (LEP) or a hospital that deters Latinos from seeking care by asking patients for citizenship information.
- Quality metrics should incorporate equity standards. For example, performance incentives should require hospitals to track translation methods used for each encounter with an LEP patient and penalize hospitals that ask family members to translate rather than using professional interpreters.
- Medical education policy must address the shortage of health care clinicians who are fluent in Spanish and who understand cultural nuances that influence health care for Latino families. Students who have those characteristics and who make legally binding commitments to work in underserved Latino communities for a defined period should receive significant federal help paying for their professional and medical education and facilitating the completion of licensing requirements.²⁴
- Many children and families in the Latino community are experiencing significant trauma due to the current federal campaign of cruel and indiscriminate immigration enforcement. [A KFF poll](#) fielded from August through October 2025, found that for half of Latino immigrants (51%), immigration-related worries have caused stress, anxiety or sadness; problems sleeping or eating; or worsening health conditions like diabetes or high blood pressure. Nearly 1 in 5 immigrant parents (18%), including nearly half of undocumented parents (46%), report that their children experience sleeping or eating problems, changes in school performance or attendance, or behavior problems. [In geographic areas where ICE has been active within the past 12 months, fully 25% of all immigrant parents report that their children have experienced increased stress, anxiety or sadness](#) due to worries about immigration status. A [special report](#) in *Psychiatric News* found that immigration enforcement has become "a source of chronic fear, instability and trauma for millions," with trauma inflicted both on "children who are themselves immigrants but also the millions of U.S.-born children living in mixed-status households — children who, despite being citizens, are deeply affected by the precarious legal status and systemic exclusion faced by their caregivers." Major investments in mental health care will be needed to prevent deep, lifelong harm that now threatens these children and their families.

In reconstructing health programs to meet the distinctive needs of particular communities, policymakers should not stop with Latinos. Rather, officials should help the full range of diverse American communities that rely on these programs, including people with disabilities, people who live in rural areas, people with specific health conditions, older adults, children (both in general and with special needs), pregnant and postpartum women, Native Americans, African Americans, and Asian Americans, Native Hawaiians and Pacific Islanders.

²² States should receive federal Medicaid match if they opt to cover all residents within defined categories, such as children who are financially eligible for Medicaid or CHIP. Moreover, localities should be allowed to cover all residents without requiring application forms, claiming federal match based on the characteristics of otherwise uninsured enrollees as shown by a statistically valid sample of claims and cases. In the past, the HHS Departmental Appeals Board has allowed states to claim matching funds based on samples. See, e.g., [New York State Dept. of Social Services, DAB No. 1134](#) (1990); [New York State Department of Social Services, DAB No. 1216](#) (1991); [Missouri Department of Social Services, DAB No. 1304](#) (1992); [Arizona Health Care Cost Containment System, DAB No. 1569](#) (1996).

²³ [The public charge guidance in effect starting in 1999](#) should be codified in statute, rather than leave public charge rules to vary as future administrations change. Such predictability is needed for people to make important decisions about their lives.

²⁴ This approach is suggested, rather than one that specifically focuses on training Latino clinicians, to limit the risks of being struck down as unconstitutional by the current U.S. Supreme Court.

Conclusion

After a period of extraordinary gains for the Latino community, the Trump administration and its congressional allies have launched an unprecedented assault on American health care. This assault is raising costs and terminating health coverage for people of all backgrounds, but Latinos are suffering especially grievous and widespread harm. Some of these attacks were launched when the so-called “One Big Beautiful Bill” made the largest cuts to health care programs in American history and when Congress refused to extend EPTCs beyond 2025. But Congress is also responsible for acquiescing to numerous policies adopted by the Trump administration that have severely damaged the Latino community’s health and health care.

Federal policymakers should repeal the legislation and reverse the administrative health care policies that have done such harm with speed and ferocity. But it will be equally important to rebuild our country’s health programs so that they do a much better job serving the millions of Americans, including Latinos, who rely on them for the health and well-being of their families and communities.

Appendix tables

Appendix Table 1. Number of people estimated to become uninsured due to OBBBA and the expiration of EPTCs, by state, race and ethnicity, if coverage losses are proportional to current enrollment

	Non-Hispanic white	Latino	African American	AANHPI	Native American	Other	Total
Alabama	76,000	11,000	55,000	3,000	3,000	4,000	151,000
Alaska	12,000	2,000	1,000	2,000	8,000	4,000	29,000
Arizona	155,000	190,000	28,000	24,000	11,000	15,000	422,000
Arkansas	86,000	14,000	27,000	5,000	1,000	5,000	139,000
California	441,000	917,000	99,000	218,000	6,000	46,000	1,727,000
Colorado	89,000	86,000	9,000	3,000	<1,000	5,000	192,000
Connecticut	63,000	54,000	19,000	4,000	<1,000	4,000	143,000
Delaware	19,000	13,000	9,000	3,000	<1,000	2,000	46,000
District of Columbia	2,000	4,000	23,000	2,000	<1,000	<1,000	32,000
Florida	384,000	858,000	206,000	33,000	<1,000	9,000	1,490,000
Georgia	182,000	88,000	147,000	71,000	6,000	6,000	500,000
Hawaii	4,000	8,000	<1,000	20,000	<1,000	11,000	42,000
Idaho	36,000	10,000	1,000	2,000	<1,000	1,000	50,000
Illinois	198,000	151,000	145,000	29,000	<1,000	6,000	528,000
Indiana	172,000	28,000	50,000	11,000	2,000	22,000	286,000
Iowa	69,000	23,000	10,000	3,000	<1,000	1,000	106,000
Kansas	37,000	9,000	11,000	<1,000	<1,000	6,000	63,000
Kentucky	153,000	16,000	35,000	3,000	<1,000	11,000	217,000
Louisiana	146,000	23,000	128,000	11,000	6,000	9,000	323,000
Maine	30,000	1,000	1,000	1,000	<1,000	<1,000	33,000
Maryland	52,000	58,000	70,000	20,000	2,000	4,000	206,000
Massachusetts	106,000	54,000	25,000	11,000	1,000	8,000	205,000
Michigan	221,000	38,000	84,000	25,000	8,000	15,000	392,000
Minnesota	100,000	32,000	22,000	13,000	4,000	8,000	180,000
Mississippi	57,000	5,000	53,000	<1,000	<1,000	<1,000	115,000
Missouri	158,000	24,000	41,000	4,000	3,000	2,000	233,000
Montana	41,000	4,000	<1,000	<1,000	3,000	2,000	50,000
Nebraska	34,000	12,000	6,000	1,000	<1,000	2,000	55,000

	Non-Hispanic white	Latino	African American	AANHPI	Native American	Other	Total
Nevada	32,000	47,000	18,000	9,000	<1,000	4,000	111,000
New Hampshire	25,000	3,000	2,000	1,000	<1,000	1,000	31,000
New Jersey	112,000	156,000	82,000	33,000	<1,000	9,000	392,000
New Mexico	21,000	54,000	3,000	3,000	16,000	2,000	97,000
New York	291,000	260,000	173,000	116,000	5,000	15,000	860,000
North Carolina	218,000	82,000	108,000	18,000	15,000	12,000	452,000
North Dakota	18,000	3,000	2,000	<1,000	2,000	1,000	26,000
Ohio	295,000	42,000	79,000	17,000	<1,000	31,000	464,000
Oklahoma	79,000	42,000	20,000	4,000	16,000	21,000	182,000
Oregon	141,000	43,000	3,000	6,000	3,000	11,000	208,000
Pennsylvania	271,000	64,000	76,000	18,000	<1,000	18,000	447,000
Rhode Island	20,000	16,000	5,000	1,000	<1,000	1,000	42,000
South Carolina	110,000	21,000	51,000	1,000	<1,000	7,000	191,000
South Dakota	16,000	2,000	<1,000	<1,000	2,000	1,000	21,000
Tennessee	144,000	43,000	19,000	<1,000	<1,000	<1,000	208,000
Texas	399,000	683,000	191,000	128,000	<1,000	29,000	1,431,000
Utah	117,000	21,000	5,000	2,000	<1,000	4,000	149,000
Vermont	16,000	<1,000	<1,000	1,000	<1,000	1,000	18,000
Virginia	162,000	51,000	85,000	30,000	1,000	21,000	349,000
Washington	196,000	129,000	16,000	25,000	27,000	29,000	422,000
West Virginia	67,000	2,000	4,000	1,000	<1,000	2,000	76,000
Wisconsin	79,000	15,000	15,000	4,000	1,000	1,000	114,000
Wyoming	9,000	1,000	<1,000	<1,000	<1,000	<1,000	10,000
Total	6,095,000	4,340,000	2,362,000	911,000	131,000	414,000	14,253,000

Source: UnidosUS analysis of data from March 2025 CPS, accessed via IPUMS, and coverage loss estimates from [KFF 2025](#).

Notes: These estimates take KFF's projected insurance losses by state and program (Medicaid, ACA health coverage and Medicare) and distribute them based on the race and ethnicity of program participants in each state in March 2025. For Medicaid and ACA health coverage, the analysis is limited to beneficiaries under age 65, since those age 65 or older are likely to have access to Medicare and thus unlikely to become completely uninsured. Enrollment in ACA health coverage in 2025 is based on self-reported enrollment into subsidized marketplace plans. Latinos are Hispanics of all races. All other categories are limited to non-Hispanics. AANHPI=Asian Americans, Native Hawaiians and Pacific Islanders. "Other" includes people of multiple races. Totals may not add up due to rounding.

Appendix Table 2. Estimated state-level distribution, by race and ethnicity, of people estimated to become uninsured due to OBBBA and the expiration of EPTCs, if coverage losses are proportional to current enrollment

	Non-Hispanic white	Latino	African	AANHPI	Native American	Other	Total
Alabama	50%	7%	37%	2%	2%	2%	100%
Alaska	41%	7%	5%	7%	28%	12%	100%
Arizona	37%	45%	7%	6%	3%	4%	100%
Arkansas	62%	10%	19%	4%	1%	4%	100%
California	26%	53%	6%	13%	<1%	3%	100%
Colorado	46%	45%	5%	2%	<1%	3%	100%
Connecticut	44%	37%	13%	3%	<1%	3%	100%
Delaware	42%	28%	20%	6%	<1%	4%	100%
District of Columbia	7%	12%	74%	5%	<1%	1%	100%
Florida	26%	58%	14%	2%	<1%	1%	100%
Georgia	36%	18%	29%	14%	1%	1%	100%
Hawaii	8%	19%	1%	46%	<1%	26%	100%
Idaho	73%	21%	1%	4%	<1%	1%	100%
Illinois	37%	29%	27%	5%	<1%	1%	100%
Indiana	60%	10%	18%	4%	1%	8%	100%
Iowa	65%	22%	9%	3%	<1%	1%	100%
Kansas	59%	14%	18%	<1%	<1%	9%	100%
Kentucky	70%	7%	16%	1%	<1%	5%	100%
Louisiana	45%	7%	40%	3%	2%	3%	100%
Maine	89%	3%	4%	2%	1%	1%	100%
Maryland	25%	28%	34%	10%	1%	2%	100%
Massachusetts	52%	27%	12%	5%	1%	4%	100%
Michigan	56%	10%	22%	6%	2%	4%	100%
Minnesota	56%	18%	12%	7%	2%	4%	100%
Mississippi	49%	4%	46%	<1%	<1%	0%	100%
Missouri	68%	10%	18%	2%	1%	1%	100%
Montana	82%	8%	1%	<1%	5%	4%	100%
Nebraska	62%	23%	10%	2%	1%	4%	100%
Nevada	29%	42%	17%	8%	<1%	4%	100%
New Hampshire	80%	9%	5%	4%	<1%	2%	100%

	Non-Hispanic white	Latino	African American	AANHPI	Native American	Other	Total
New Jersey	28%	40%	21%	8%	<1%	2%	100%
New Mexico	21%	56%	3%	3%	16%	2%	100%
New York	34%	30%	20%	13%	1%	2%	100%
North Carolina	48%	18%	24%	4%	3%	3%	100%
North Dakota	68%	10%	8%	1%	8%	6%	100%
Ohio	64%	9%	17%	4%	<1%	7%	100%
Oklahoma	43%	23%	11%	2%	9%	12%	100%
Oregon	68%	20%	2%	3%	2%	5%	100%
Pennsylvania	61%	14%	17%	4%	<1%	4%	100%
Rhode Island	47%	37%	13%	1%	<1%	1%	100%
South Carolina	58%	11%	27%	1%	<1%	4%	100%
South Dakota	79%	7%	0%	<1%	10%	3%	100%
Tennessee	69%	21%	9%	<1%	<1%	0%	100%
Texas	28%	48%	13%	9%	<1%	2%	100%
Utah	78%	14%	3%	2%	<1%	3%	100%
Vermont	88%	1%	1%	6%	<1%	4%	100%
Virginia	46%	15%	24%	8%	<1%	6%	100%
Washington	46%	31%	4%	6%	6%	7%	100%
West Virginia	89%	3%	5%	1%	<1%	2%	100%
Wisconsin	69%	13%	13%	3%	1%	1%	100%
Wyoming	91%	9%	0%	<1%	<1%	0%	100%
Total	43%	30%	17%	6%	1%	3%	100%

Source: UnidosUS analysis of data from March 2025 CPS, accessed via IPUMS, and coverage loss estimates from [KFF 2025](#).

Notes: These estimates take KFF's projected insurance losses by state and program (Medicaid, ACA health coverage and Medicare) and distribute them based on the race and ethnicity of program participants in each state in March 2025. For Medicaid and ACA health coverage, the analysis is limited to beneficiaries under age 65, since those age 65 or older are likely to have access to Medicare and thus unlikely to become completely uninsured. Enrollment in ACA health coverage in 2025 is based on self-reported enrollment into subsidized marketplace plans. Latinos are Hispanics of all races. All other categories are limited to non-Hispanics. AANHPI=Asian Americans, Native Hawaiians and Pacific Islanders. "Other" includes people of multiple races.



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