CAMPAIGN FOR
COMMUNITY HEALTHCARE

Seamless, Accountable & Fair:

A Civil Rights Agenda for Reconstructing Insurance Affordability Programs

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CAMPAIGN FOR COMMUNITY HEALTHCARE

Seamless, Accountable and Fair: A Civil Rights Agenda for Reconstructing Insurance Affordability Programs is a joint report from nine civil rights and health equity organizations of the Campaign for Community Healthcare: the Asian & Pacific Islander American Health Forum, NAACP, the National Council of Negro Women, the National Urban League, the Southern Poverty Law Center, UnidosUS, the Coalition on Human Needs, Community Catalyst, and Families USA.

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Executive Summary

In recent years, earthshaking changes transformed America's Insurance Affordability Programs (IAPs): namely, Medicaid, the Children's Health Insurance Program (CHIP) and private coverage purchased through the Affordable Care Act (ACA) Marketplace.

In 2023 and 2024, Medicaid unwinding brought pandemic protections to an end, as states redetermined eligibility for roughly 90 million beneficiaries. An estimated 27 million people were terminated, of whom 7 in 10 lost Medicaid for entirely procedural reasons—most often nothing more than missing paperwork. Many transitioned to other coverage or eventually returned to Medicaid, but nearly one-fourth became uninsured.

Beginning in January 2025, IAPs came under fierce attack. Enactment of the so-called "One Big Beautiful Bill Act" (OBBBA) and Congress's failure to extend enhanced premium tax credits (EPTCs) are expected to increase the number of uninsured by approximately 14 million. At least 60% of those losing coverage are estimated to be people of color. The health coverage losses projected by the Congressional Budget Office (CBO) during President Trump's current term exceed, by a considerable margin, any previous four-year decline in history.

Reversing recent cuts is necessary but not sufficient. Even as health coverage reached its height in 2023, far too many Americans remained uninsured, especially in marginalized communities. When the next short-term window opens for achieving significant national progress, policymakers must seize that opportunity to reconstruct IAPs in a way that better serves beneficiaries, without leaving people of color behind.

People from historically marginalized communities have a huge stake in IAP reconstruction. Because of longstanding systemic racism, many people from such communities work low-wage jobs without health benefits, making IAPs essential. Thus, people of color comprise more than 60% of Medicaid beneficiaries and more than 50% of people purchasing ACA insurance.

Health coverage is critically important to the individuals who obtain it. Coverage greatly increases access to care, improving health outcomes and saving lives. When properly structured, health insurance protects families'[1] financial security by shielding them from unaffordable medical bills.

Health insurance is also important to communities. When more people are insured, uncompensated care costs drop, lowering hospital charges and insurance premiums. A stronger, better-funded provider infrastructure gives all community residents, including people with private insurance, higher quality and more accessible care. And infectious disease is detected and treated far more effectively when people who feel sick can afford to go to the doctor.

Following the ACA's enactment in 2010, 28 million people gained health coverage, 60% of whom came from historically marginalized communities. Insurance disparities greatly narrowed between non-Hispanic whites and people of color. Nevertheless, America's remaining uninsured increasingly live in historically marginalized communities. While the total number of uninsured has fallen, the percentage of uninsured Americans who are people of color has surged from 55% in 2010, when the ACA passed, to nearly two-thirds (64%) in 2024. If our country abandons its generations-long quest to ensure that everyone has the health insurance they need to thrive, historically marginalized communities will pay a steep price.

1 This report uses the term, "families," to include households of all configurations and sizes.

Both recent events and longer-term history teach seven key lessons that can inform the reconstruction of IAPs:

1 Paperwork and red tape are powerful weapons for denying people health coverage, disproportionately harming historically marginalized communities.

Scholars term such administrative burdens, "handmaidens of the racialized state," for good reason. People of all races and ethnicities lost Medicaid during unwinding because of nothing more than missing paperwork. However, Black and Latino[2] beneficiaries were twice as likely to be unable to complete the redetermination process, compared to non-Hispanic whites; and Asian American, Native Hawaiian and Pacific Islander (AANHPI) beneficiaries were 50% more likely. In routine redeterminations, 52% of Latinos, 48% of African Americans, and 44% of AANHPI beneficiaries terminated from Medicaid are **eligible but lose coverage anyway** because of paperwork glitches. The same is true for 40% of non-Hispanic whites—far too many, but significantly fewer than for people of color.

During President Trump's current term, administrative burdens have posed an especially grave danger. Such burdens are responsible for three-fourths of all coverage losses CBO estimates will result from OBBBA, the most significant of which terminates Medicaid for low-income adults who do not document employment or exemption from work requirements. Recent administration rulings have worsened the latter burdens, requiring the termination of chronically ill people unless they document details of their conditions not found in medical records.

A top priority for IAP reconstruction must be a dramatic reduction of families' administrative burdens.

2 States vary greatly in how they treat people who rely on IAPs.

Whether eligible people are insured or denied coverage often depends on the state where they happen to live, as shown by events during unwinding:

- In the 10 states with the fewest terminations, just 18% of beneficiaries lost Medicaid. Nearly three times as many—50%—were terminated in the ten states with the highest such levels. If all states did as well as the 10 best, 7 million additional people would have kept their Medicaid by the end of unwinding.
- In the 10 states that did the most to proactively seek out available data and assess eligibility before asking families for documents, two-thirds (65%) of all beneficiaries experienced paperless, data-based renewal. By contrast, in states that most often demanded paperwork without first seeing whether available information already showed eligibility, just 22% of beneficiaries were renewed based on data matches.

IAP reconstruction must create clear performance standards that require each state to do the work needed to cover all eligible families.

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

3 Underfunding agency staff and program infrastructure can severely exacerbate administrative burdens.

Illustrating the impact of inadequate infrastructure, the average Spanish-language caller to Florida's Medicaid call center had to wait more than two hours to reach a person during Medicaid unwinding, preventing many eligible families from renewing their insurance. And in Texas, anonymous whistleblowers reported that staff shortages and obsolete computers caused nearly 100,000 people to wrongly lose Medicaid coverage, including pregnant women for whom even a brief coverage interruption can have catastrophic consequences.

IAP reconstruction must ensure adequate resources for information technology and staff.

4 Using both high-tech and high-touch approaches, government agencies have prevented administrative burdens from denying people healthcare.

For example:

- Even though some states did a terrible job protecting families' coverage, most states made remarkable progress during unwinding in cutting paperwork demands by proactively accessing data and using it to preserve eligible people's coverage. The proportion of paperless renewals based entirely on data matches more than doubled nationally, rising from 25% to 55% of people going through redetermination, while the proportion of procedural terminations plummeted from 29% to 11%.
- Federal Marketplace officials reached out to families terminated from Medicaid and offered hands-on help completing paperwork. As a result, 3 million people who were terminated from Medicaid during unwinding successfully transitioned to the federal ACA Marketplace.

It is feasible and therefore imperative for IAP reconstruction to protect families' coverage through both data-driven, seamless eligibility systems and hands-on assistance from knowledgeable human beings.

5 Neither federal agencies nor the courts have been fully reliable protectors of marginalized communities.

- **Agencies can fall short.** Even in a federal administration friendly to marginalized communities, agencies can be stymied by resource limits. They can also hesitate to take enforcement action without support from utterly unambiguous statutes or regulations, fearing that states could make bad law by challenging enforcement actions in handpicked federal courts.
- **The courtroom door is typically closed to families who are harmed by IAP legal violations.** The U.S. Supreme Court has made it nearly impossible for families who rely on Medicaid to seek judicial orders stopping states from violating the Medicaid statute. The Court has also ruled that, without a "smoking gun" proving intent to discriminate, civil rights lawsuits cannot stop state agencies from causing disproportionate and unjustified harm to people of color.

IAP reconstruction must include strong new mechanisms to hold IAP agencies accountable to the families they serve.

6 Immigrant scapegoating, rhetoric with racist undertones, and unsupported allegations of fraud and abuse have been used to justify fierce attacks on families who rely on IAPs for health care.

Illustrating such emotionally charged misinformation, when OBBBA ended coverage for more than 1 million lawfully present immigrants, federal officials mischaracterized those immigrants as undocumented; racist stereotypes undergird efforts to terminate Medicaid for adults who neither document work nor prove exemption from work requirements; and unsupported allegations of waste, fraud and abuse have been used to justify the expiration of EPTCs, unprecedented denials of federal Medicaid funds to states led by Democratic governors, and even the entirety of OBBBA's historic healthcare cuts.

IAP reconstruction should try to limit the vulnerability of both programs and families to unfounded accusations.

7 Administrative policies with decades of bipartisan support are vulnerable unless they are embodied in statute.

Overturning longstanding protections, the Trump administration has proposed policies such as imposing immigration status limits on community health center services and requiring proof of discriminatory intent before federal agencies can strike down practices that cause disproportionate harm to people of color.

Whenever possible, IAP reconstruction should place key safeguards in statutes, not just regulations.

In view of these lessons, three fundamental changes are required for IAPs to provide health coverage to all in need, without leaving behind people from historically marginalized communities:

1 IAPs must become substantially more seamless and paperless for families.

- People should automatically qualify for coverage based on prior-year tax returns or participation in the Supplemental Nutrition Assistance Program (SNAP). In every racial and ethnic group, that would eliminate administrative burdens at renewal for 80% or more of Medicaid beneficiaries and enable paperless enrollment into health coverage for at least 75% of people without health insurance.[3] Defining eligibility in terms that can be verified based on data would also limit IAPs' vulnerability to charges of fraud and abuse.
- In every state, a single system should determine eligibility for all health programs, so families aren't forced to go from agency to agency to find the program for which they qualify.
- Targeted funding should be guaranteed for IAP technology and staff as well as independent consumer assistance, and IAP agencies should be accountable to meet standards that limit families' administrative burdens. For example, if a state does not proactively use available data to renew at least a minimum percentage of Medicaid families, it should be barred from terminating people for procedural reasons.

2 IAPs should be accountable to the communities they serve.

Families should have the right to go to court to stop IAP legal violations, including actions that cause disproportionate and unjustified harm to people of color. And if a state sues to stop the Centers for Medicare & Medicaid Services (CMS) from enforcing legal standards that protect families from harm, the litigation should be heard in the District of Columbia, so states cannot escape accountability by handpicking the judges who will try their cases.

3 IAPs should treat everyone fairly, including people from historically marginalized communities:

- People with incomes below the federal poverty level who are denied coverage by their state's refusal to expand Medicaid should qualify for ACA healthcare, with financial support and benefits that provide Medicaid-level protection.
- Lawfully present immigrants, living in the U.S. with the knowledge and permission of the federal government, should not be denied IAP eligibility based on immigration status. People should be able to use their own money to buy ACA health insurance, regardless of immigration status. And if they so choose, states and localities should have viable options for covering all their residents in need.
- Federal statutes should guarantee immigrants the right to seek health coverage for which they qualify, without endangering future improvements to their families' immigration status.

3 Such an approach has ample precedent. Prior-year income tax data establishes minimum, guaranteed eligibility for college student aid and means-tested premiums for Medicare Parts B and D. And more than 90% of Medicare beneficiaries who receive low-income subsidies to help purchase prescription drug coverage qualify based on their participation in Medicaid, cash assistance and other programs, without any need to complete paperwork.

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Introduction

In recent years, Insurance Affordability Programs (IAPs) have experienced serious disruptions that harmed Americans from all backgrounds but hit with particular force in historically marginalized communities:

- In 2023 and 2024, Medicaid transitioned out of COVID-19 coverage protections, forcing states to redetermine eligibility for 90 million people. During that unwinding, states terminated 27 million people, 70% of whom lost Medicaid because of nothing more than missing paperwork.
- In 2025 and 2026, federal officials enacted legislation that is expected to terminate coverage for 14 million people, at least 60% of whom are estimated to come from historically marginalized communities. According to CBO projections, the United States is now experiencing the largest four-year health coverage losses since the Census Bureau first began reporting reliable coverage numbers in the mid-1980s.

It is necessary but not sufficient for federal policymakers to reverse recent policy choices. Even when health coverage reached its height in 2023, far too many Americans remained uninsured, were denied necessary healthcare and were forced to shoulder the burdens of unaffordable health costs. Each of those problems was especially acute in communities of color. Rather than return to an insufficient status quo, our country must heed the lessons taught by the tumultuous history of IAPs and reconstruct those programs to do a far better job meeting people's needs, without leaving anyone behind because they live in historically marginalized communities.

This report maps out a civil rights agenda for IAP reconstruction, focused on one simple goal: broadening the circle of health coverage to serve as many people as possible, including families in communities of color. We begin by explaining the importance of that goal and distinguishing it from other important health policy objectives that fall outside the scope of this report. We then identify lessons learned from three sets of events: the massive redetermination of Medicaid eligibility in 2023 and 2024, the unprecedented attacks on American healthcare that the federal government launched in 2025 and 2026, and longer-term IAP history. Building on those lessons, we articulate a vision for reconstructed health programs that will do a far better job meeting the needs of all Americans, including those who have been left behind for far too long.

Why health coverage? And why now?

What this report does not address

This report articulates a civil rights and health equity agenda for IAPs that will bring the benefits of health coverage to as many people as possible, with full and equitable inclusion of people of color. Other equally important issues fall outside the report's scope, including:

- Health inequities that arise along lines other than race and ethnicity. For example, people with disabilities, older adults, LGBTQ+ people, and many children face terrible inequities that require vigorous national action.
- Health inequities that involve race and ethnicity but go beyond enrollment in comprehensive, affordable health coverage. For example, many communities of color experience reduced lifespan and shockingly high levels of serious medical problems, including maternal mortality, untreated mental health and substance use disorders and other chronic conditions; healthcare itself requires reinvention to become more linguistically accessible and culturally attuned; historically marginalized communities often face acute provider shortages, especially among clinicians who come from those communities; racism pervades the healthcare system, just as it does almost every other arena of American life; and current policies of extreme and cruel immigrant enforcement are causing trauma and long-term mental and emotional health problems for millions of children and families in Latino and AANHPI communities.
- Proposals to radically restructure the entire healthcare system, such as Medicare for All plans.

Even though topics like these are outside this report's scope, they are no less important than the problems discussed here, and they warrant significant attention from advocates and policymakers alike.

The importance of covering all Americans, without unfairly disadvantaging people from marginalized communities

It is imperative for our nation's leaders to ensure health coverage for all Americans, including those from communities of color, for five reasons.

1. When people lack health coverage, they and their families suffer.

Since the ACA's enactment, a mountain of research has documented the importance of coverage to health and well-being, to families' financial stability, and even to people's survival.[4]

2. When many families are uninsured, communities are damaged, hurting even the people who have insurance.

- Health insurance premiums and other costs rise when healthcare providers are not paid for their services. Forced to delay care until problems become acute, many uninsured people turn to hospital emergency rooms, the most expensive medical setting. In emergencies, hospitals are legally required to furnish stabilizing care, even when the patient is uninsured and unable to pay. The resulting uncompensated costs can be passed on to others through higher hospital charges and increased insurance premiums.
- Revenue shortfalls degrade provider networks, undermining access and quality of care for everyone. According to leading health economists, in communities with numerous uninsured, people **with insurance** are far less likely to have a place to go when they get sick and much more likely to have trouble finding a specialist, to have unmet needs for medical care and to receive poor quality care.
- Infectious disease can spread, undetected and untreated, when community members who feel sick cannot afford to see a doctor. During the height of the COVID-19 pandemic:
  - One study found that each 10% increase in the proportion of a county's residents who lacked health insurance was associated with a 70% increase in COVID-19 cases and a 48% increase in COVID-19 deaths.

4 Recent summaries of evidence include ASPE Office of Health Policy, June 7, 2024; and KFF, June 16, 2026.

- Another study found that each 5% increase in the proportion of a county's residents who lacked health insurance was associated with a 41% increase in COVID-19 deaths in urban counties and a 22% increase in rural counties.

3. IAPs are important to Americans from all backgrounds, but they are especially important to historically marginalized communities.

Because of a long history of systemic racism, people from such communities often work in low-wage jobs without health benefits, creating both the need and eligibility for IAPs. Consequently, 62% of Medicaid beneficiaries under age 65 and 52% of people who buy ACA private insurance are people of color, compared to 47% of the total population under age 65 **(Figure 1)**.

4. IAP expansions and affordability improvements that began with the ACA's passage benefited people of all races and ethnicities, with particular gains experienced by members of historically marginalized groups. But now those gains are in jeopardy from the health care attacks that began in 2025.

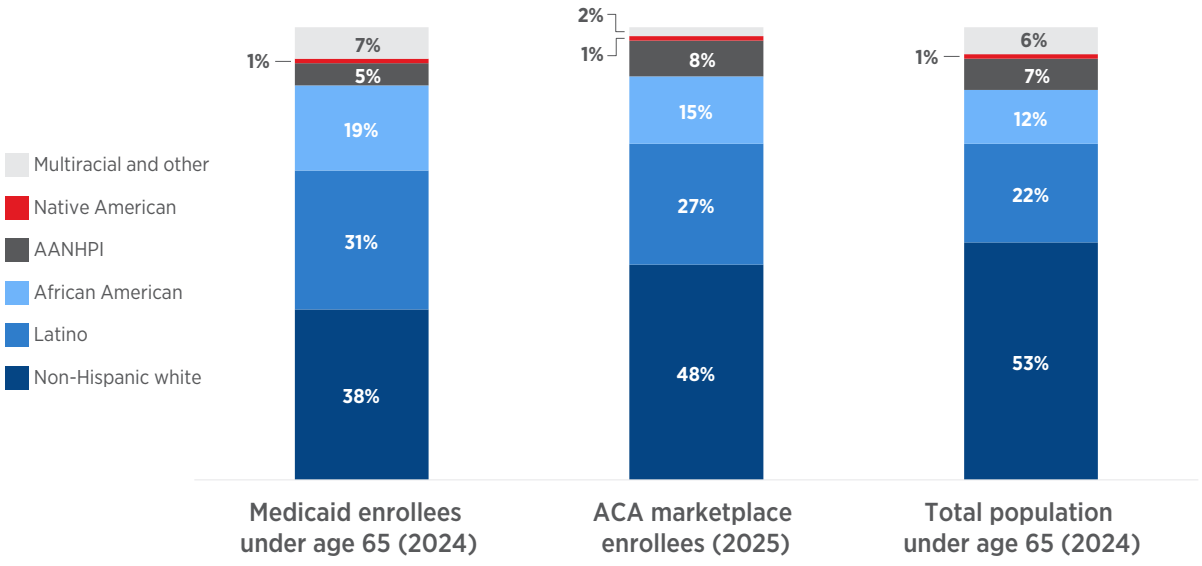
From 2010 (when the ACA passed) to 2024, the percentage of people without coverage fell from 11.1% to 5.4% among non-Hispanic whites; 31.2% to 17.2% for Latinos; 19.1% to 9.6% among African Americans;15.6% to 5.3% for AANHPIs; and 30.0% to 17.1% for Native Americans **(Figure 2)**.

Millions of people gained health insurance coverage following the ACA's enactment. If the percentage of people without insurance had remained unchanged from 2010 to 2024, 28 million fewer Americans would have had health coverage in 2024. More than three in five (61%) people covered because of higher insurance rates come from historically marginalized communities, including 9.5 million Latinos, 3.8 million African Americans, 2.2 million AANHPIs and 200,000 Native Americans **(Table 1)**.

From 2010 to 2024, IAPs moved America towards health equity, but the journey was far from complete. Even after ACA implementation, the proportion of people without health insurance was much higher in communities of color than among non-Hispanic whites. Compared

Figure 1. More than half of IAP participants come from historically marginalized communities

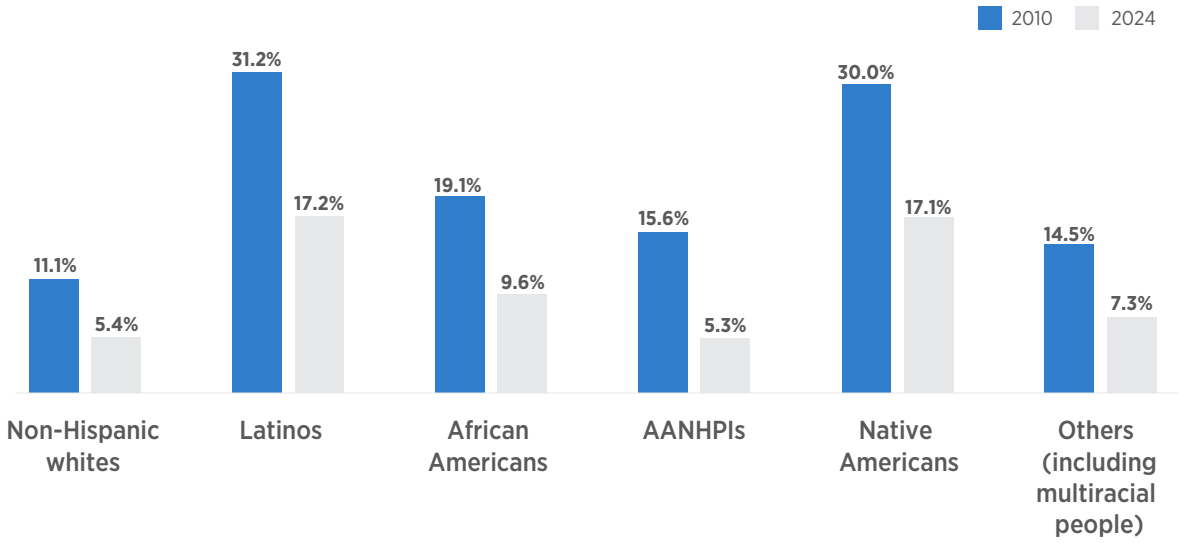
Enrollment in Medicaid and ACA Marketplace coverage, by race and ethnicity, compared to total population



Sources: KFF, UnidosUS, UnidosUS analysis of 2024 American Community Survey (ACS) data, accessed through IPUMS, University of Minnesota, www.ipums.org (IPUMS).
Note: Latinos are Hispanics of all races. All other racial and ethnic groups are limited to non-Hispanics. AANHPI = Asian American, Native Hawaiian and Pacific Islander.

Figure 2. People from all backgrounds experienced significant coverage gains between the ACA's 2010 enactment and 2024

Percentage of people without any health insurance, by race and ethnicity: 2010 vs. 2024



Source: UnidosUS analysis of ACS data for 2010 and 2024, accessed through IPUMS.

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

Table 1. Millions of Americans gained health coverage following the ACA's passage

The number of additional uninsured in 2024, if the percentage of people without health insurance was unchanged since 2010, by race and ethnicity (millions of people)

	Uninsured in 2024	If the proportion of uninsured was the same as in 2010, the number who would be uninsured in 2024	People who had coverage in 2024 due to higher insurance rates
Non-Hispanic whites	10.3	21.2	10.9
Latinos	11.7	21.2	9.5
African Americans	3.8	7.6	3.8
AANHPIs	1.1	3.3	2.2
Native Americans	0.3	0.5	0.2
Others (including multiracial people)	1.3	2.5	1.3
Total	**28.6**	**56.5**	**27.9**

Source: UnidosUS analysis of ACS data for 2010 and 2024, accessed through IPUMS.

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

to non-Hispanic whites, African Americans in 2024 were nearly twice as likely to be uninsured (9.6% vs. 5.4%), and Latinos were nearly three times as likely (17.2% vs. 5.4%) (Figure 2). Even so, racial and ethnic disparities fell significantly from 2010 to 2024 **(Figure 3)**:

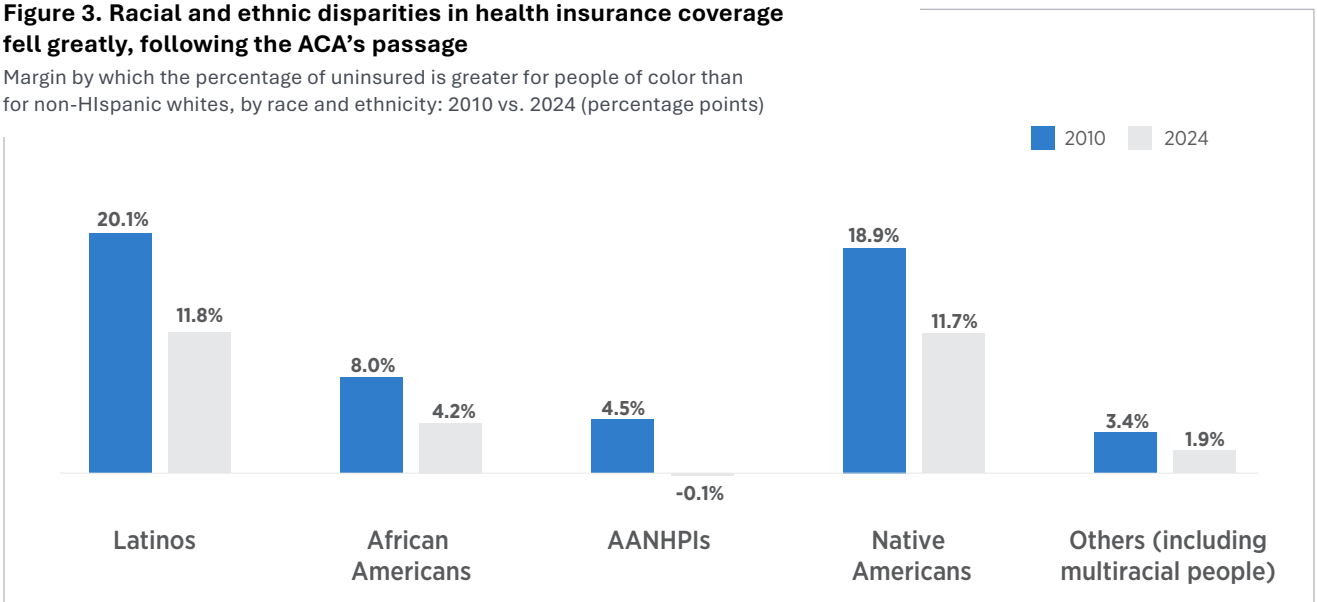
- The difference between the percentage of uninsured among Latinos and non-Hispanic whites fell by 8.3 percentage points, from 20.1% to 11.8%
- That difference fell by 3.8 percentage points for African Americans, from 8.0% to 4.2%.
- The disparity dropped by 4.6 percentage points for AANHPIs, for whom the proportion without coverage went from 4.5% higher than non-Hispanic whites to 0.1% lower.
- Disparities fell by 7.2 percentage points for Native Americans, declining from 18.9% to 11.7%.

5. An ever-increasing proportion of people without health insurance comes from historically marginalized communities.

Our country will be forsaking communities of color if it abandons the generations-long struggle to ensure that every family in America has the health insurance they need to thrive. While the number of uninsured Americans fell from almost 50 million to fewer than 30 million, the proportion of uninsured people who come from communities of color surged from 55% in 2010 to 64% in 2024 **(Figure 4)**.

Figure 3. Racial and ethnic disparities in health insurance coverage fell greatly, following the ACA's passage

Margin by which the percentage of uninsured is greater for people of color than for non-HIspanic whites, by race and ethnicity: 2010 vs. 2024 (percentage points)

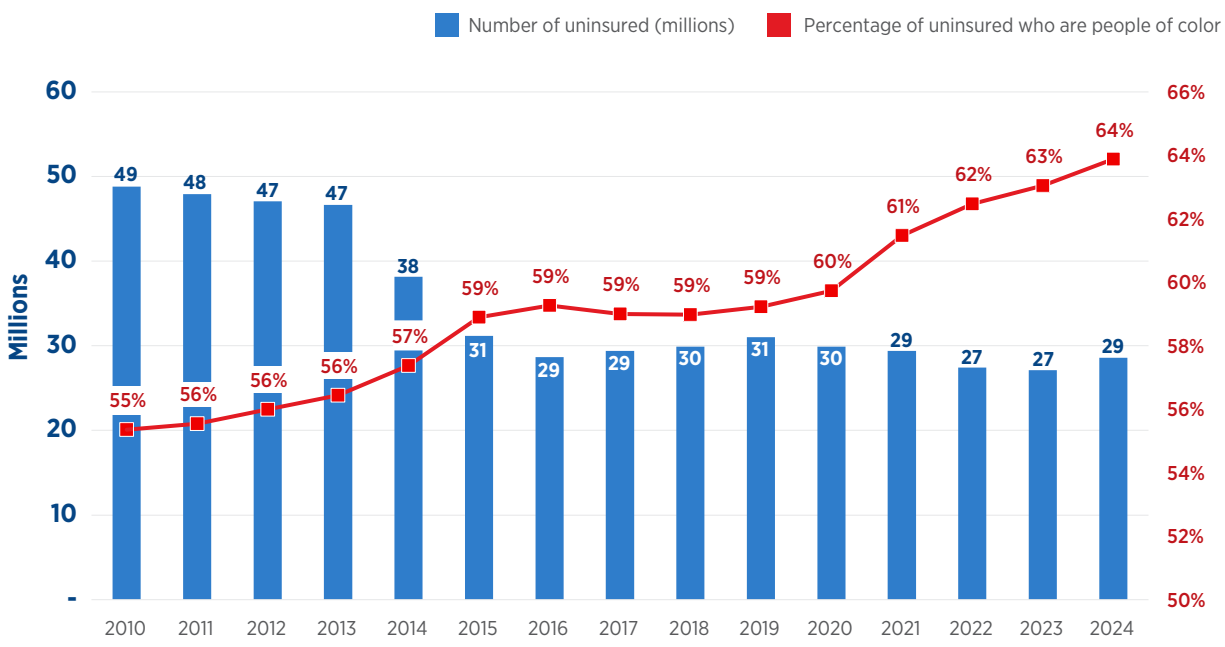


Source: UnidosUS analysis of ACS data for 2010 and 2024, accessed through IPUMS.

Note: The graph shows the number of percentage points by which the percentage of uninsured in each identified group exceeded the percentage of uninsured non-Hispanic whites. Latinos are Hispanics of all races. All other racial and ethnic groups are limited to non-Hispanics. AANHP = Asian American, Native Hawaiian and Pacific Islander. The negative number of AANHPIs in 2024 shows that a slightly smaller percentage of people were uninsured in the AANHPI community than among non-Hispanic whites.

Figure 4. Many fewer Americans are uninsured than in 2010, but the proportion of uninsured who are people of color has increased dramatically

The number of uninsured (millions) and the percentage of uninsured who are people of color, 2010-2024



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

Note: People of color are everyone but non-Hispanic whites.

Now is the time to chart a path forward

More than a decade of hard-won gains from stronger IAPs are now at risk, from both legislation and administration policies. During the four years of President Trump's second term, the Congressional Budget Office projects an increase in the number of uninsured larger than any previous four-year increase in American history recorded in reliable Census Bureau data. Over the next 10 years, the combination of OBBBA's IAP cuts and Congress's decision to let EPTCs expire is projected to terminate health insurance for 14 million Americans. Even if coverage losses are no more likely for beneficiaries of color than for non-Hispanic white beneficiaries,[5] almost 60% of everyone expected to become uninsured will come from historically marginalized communities, including:

- 4.3 million Latinos
- 2.4 million African Americans
- Nearly 1 million Asian American, Native Hawaiian and Pacific Islanders
- Approximately 100,000 Native Americans

These coverage losses will deepen current problems, putting great strain on hospitals, clinics and other healthcare providers that, in many cases, already struggle to meet community needs. In the country as a whole, the number of uninsured is projected to increase by a staggering 50% above 2024 levels **(Table 2)**. But for African Americans and AANHPIs, the proportionate increase is much larger—62% and 80%, respectively—showing the particularly serious dangers facing critical healthcare infrastructure in those communities.

5 Beneficiaries from historically marginalized communities will be more likely than non-Hispanic white beneficiaries to lose health coverage and become uninsured, for the reasons discussed in the UnidosUS 2026 Latino healthcare report. Accordingly, people of color are likely to comprise significantly more than 60% of those who lose coverage.

Table 2. Coverage losses projected to result from the One Big Beautiful Bill Act and EPTC expiration will substantially increase the number of uninsured, relative to current levels

The number of uninsured in 2024 vs. projected 10-year increases in the number of uninsured, by race and ethnicity, if beneficiaries of all races and ethnicities are equally likely to lose coverage

	Uninsured in 2024 (millions of people)	Additional uninsured (millions of people)	Percentage increase
Non-Hispanic whites	10.3	6.1	59%
Latinos	11.7	4.3	37%
African Americans	3.8	2.4	62%
AANHPIs	1.1	0.9	80%
Native Americans	0.3	0.1	43%
Others (including multiracial people)	1.3	0.4	32%
Total	**28.6**	**14.3**	**50%**

Sources: UnidosUS analysis of 2024 ACS data, accessed through IPUMS; UnidosUS, May 2026.

In addition to these legislative attacks, a host of administration policies threaten health coverage in historically marginalized communities:

- Within weeks of President Trump taking office, his administration eliminated 90% of funding for health insurance navigators that help people enroll in IAPs and renew coverage.
- The combination of indiscriminate immigration enforcement, sharing of confidential personal Medicaid records with U.S. Immigration and Customs Enforcement's (ICE), and proposed harsh public charge regulations has created a tremendous chilling effect in immigrant communities. Many families now avoid participating in health programs or even seeking healthcare, fearing they could become targeted for immigration enforcement or denied future improvements in immigration status.
- The Trump administration eliminated ACA coverage for people with Deferred Action for Childhood Arrivals (DACA) status, who were brought to America as children and have known no other home.
- 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 discretionary federal grants. No such limits have applied to these healthcare programs in the past, under either Republican or Democratic administrations, including the first Trump administration.
- 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 would increase consumer costs and impose major new paperwork burdens that prevent people from obtaining insurance.[6] The first set of regulations was finalized largely as proposed, but most of its provisions were stopped in court. The second set was finalized in late May, and litigation has been filed seeking to prevent its implementation. The damage wrought by these rules would have a particularly severe impact in historically marginalized communities, as people of color buy more than half of ACA health coverage (52%).
- The administration is targeting several states run by Democratic governors for unprecedented financial sanctions based on largely unsubstantiated claims

6 For a comprehensive analysis of both rules, see the series of posts in *Health Affairs Forefront* by Georgetown University Professor Katie Keith, JD, MPH, on February 17, 2026; February 13, 2026; February 11, 2026; August 22, 2025; June 27, 2025; and June 23, 2025.

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 future payments. Federal officials then sent letters to California, Maine and New York signaling the start of similar attacks, followed by the imposition of more than $1 billion in federal funding deferrals for California, with additional cuts threatened for the future. In California and New York alone, people of color comprise more than three-fourths of all Medicaid beneficiaries. Since states are legally required to balance their budgets, large cuts in these states' federal Medicaid funding could lead them to create or lengthen waiting lists, stop covering essential services, cut payments to healthcare providers or terminate previously eligible people—all of which would be disproportionately harmful to members of historically marginalized communities.

Recent events have provided essential information needed to plan a better future. The above-described federal attacks on American healthcare waged in 2025 and 2026 have exposed weaknesses that need to be corrected as IAPs are reconstructed. Moreover, lessons are still fresh from Medicaid unwinding, the massive redetermination of Medicaid eligibility that took place in 2023 and 2024. At the time, the country transitioned out of COVID-19 coverage guarantees, so states had to reevaluate the eligibility of roughly 90 million people. According to the Government Accountability Office (GAO), states terminated 27 million people's Medicaid. While many moved to other coverage or returned to Medicaid, nearly one in four people cut from the program (23%) became uninsured.

In all, 7 in 10 terminations during unwinding (69%) involved people who lost Medicaid for entirely procedural reasons—most often nothing more than missing paperwork. Between April 2023 and July 2024, the number of people covered by Medicaid fell by 14.3 million during unwinding, representing a 16.4% net decline.[7]

Combined with an understanding of longer-term trends, both Medicaid unwinding and the current assault on health coverage can inform the country's decisions about how to reconstruct America's IAPs.

7 Source: UnidosUS analysis of CMS, Medicaid and CHIP Eligibility Operations and Enrollment Snapshot Data, April 2023 and July 2024 (CMS Medicaid Snapshot Data). In some ways, the net drop in Medicaid enrollment understates the magnitude of harm caused by Medicaid unwinding. This metric offsets terminations with new people enrolling into coverage and former beneficiaries rejoining the program.

Lessons learned

Several important themes emerge from both Medicaid unwinding and more recent IAP attacks. Combined with a clear understanding of challenges that long preceded recent events, the following seven lessons learned should help shape the country's reconstruction of IAPs.

1. Paperwork, red tape and bureaucracy are powerful weapons that can be used to deny eligible people health coverage, with disproportionate effects on historically marginalized communities.

After analyzing practices across a variety of domains, including public benefit programs, voting rights and immigration enforcement, leading public administration scholars Ray, Herd, and Moynihan made important observations in January 2023 about the role played by administrative burdens:

> *"Administrative burdens serve as the handmaiden of the racialized state... Racialized burdens are a type of administrative practice that normalizes and reinforces patterns of racial inequality in public services, simultaneously reproducing disparate treatment while obscuring discrimination because bureaucratic actors are 'just following the rules.' Racialized burdens emerge via intentional (but plausibly deniable) rules or facially neutral rules that disproportionately harm marginalized racial groups."*

Soon after their publication, these observations came to life in Medicaid unwinding. As noted earlier, seven out of every ten Medicaid beneficiaries terminated when their eligibility was being evaluated lost coverage for purely administrative reasons. People of all backgrounds suffered, but families from historically marginalized communities experienced the greatest losses. Compared to non-Hispanic white beneficiaries **(Figure 5)**:

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

That same pattern was evident before Medicaid unwinding. At regular Medicaid redeterminations, a very high percentage of people who are terminated are in fact eligible. That percentage is especially elevated for people of color. During standard reviews, more than half of Latinos terminated from Medicaid (52%) **lose coverage despite remaining eligible**, as do nearly half of African Americans (48%) and AANHPIs (44%) **(Figure 6)**. By contrast, 40% of non-Hispanic white beneficiaries who are terminated nonetheless qualify for the program—still far too many, but less than in communities of color.

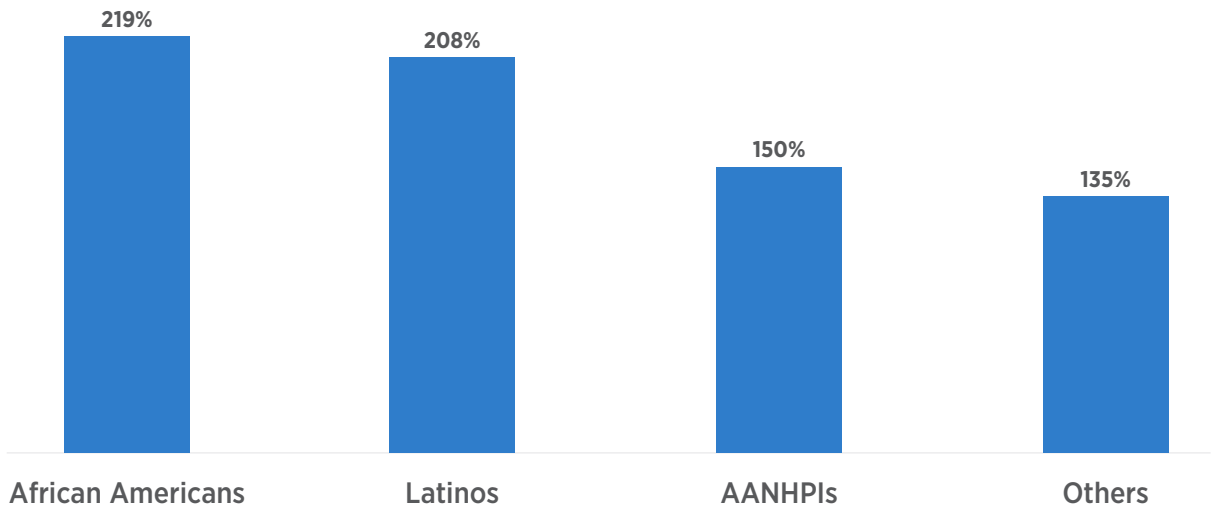
Administrative burdens have also played a central role in the IAP attacks that began in 2025. Such burdens are responsible for nearly three-fourths of all coverage losses (72%) CBO projects to result from OBBBA.[8] OBBBA's two provisions that are projected to cause the greatest increase in the number of uninsured Americans involve significant new paperwork requirements, starting in 2027:

- Adults covered through Medicaid expansion will be denied coverage if they fail to document either employment or exemption from work requirements. In the past, most people terminated by such policies have, in truth, been either working or exempt from work requirements but lost coverage anyway because of nothing more than missing paperwork. As Urban Institute scholars have observed, work requirements "can be an intentional mechanism to reduce program access for people who are eligible."
- Medicaid expansion adults will be required to reestablish their eligibility every six months, even if no information suggests any changes to their circumstances.

8 The provisions included in this estimate are the repeal of a Biden administration regulation streamlining Medicaid and CHIP enrollment and renewal; the requirement to redetermine eligibility for Medicaid expansion adults every six months; terminating Medicaid for such adults who do not document employment or exemption from work requirements; and new documentation requirements for ACA tax credit eligibility. Source: UnidosUS analysis of CBO, Estimate of Annual Changes in the Number of People Without Health Insurance Under Title VII, Public Law 119-21, August 11, 2025.

Figure 5. 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

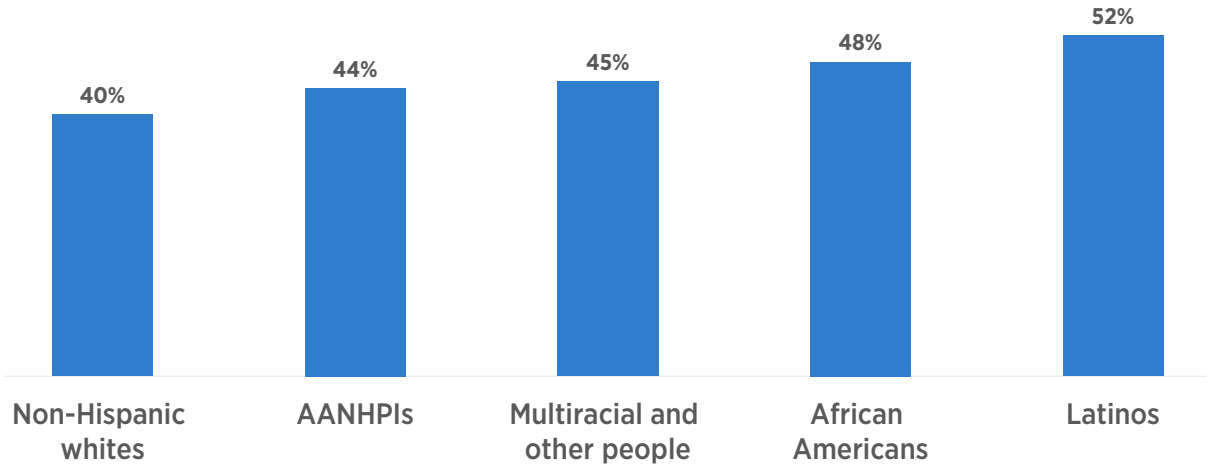


Source: Rumalla, et al., JAMA Intern Med, 2024.

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

Figure 6. When Medicaid eligibility is being redetermined, people of color are especially likely to be terminated despite remaining eligible

Among beneficiaries terminated from Medicaid during 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.

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

Recent Urban Institute research suggests that these two provisions alone will cause approximately 8 million people to become uninsured.[9]

The Trump administration's recent regulation on Medicaid work documentation requirements made these administrative barriers substantially worse. The statute exempts people with serious health problems from these requirements. Based on guidance from CMS, many states were building information systems that proactively used medical records to automatically identify people with diagnoses of serious illness and shield them from termination for failure to document work. The regulation released by the Trump administration in June forbids such steps to prevent paperwork-based terminations. Instead, even when people are known to have diagnoses of serious health problems, the regulation requires them to present documents, not found in medical records, that those problems prevent them from working. Compounding these new administrative burdens, the regulations forbid granting exemptions based on statements, under penalty of perjury, from patients explaining how their medical problems interfere with work. Instead, patients will be denied healthcare unless they obtain paperwork, such as written statements from healthcare providers, and present it to the state.

Clearly, a radical reduction in administrative burdens must be a central feature of IAP reconstruction.

2. States vary enormously in how well they serve the people who rely on IAPs for health coverage

During Medicaid unwinding, states were required to report much more information about redetermination than is available for any other period. This data showed enormous variation in the protection states afforded families. For example **(Figure 7)**:

- In the 10 states with the fewest terminations, just 18% of beneficiaries had their Medicaid taken away. Nearly three times as many—50%—had Medicaid terminated in the ten states with the highest termination levels.
- In the 10 states that did the most to proactively seek out available data to verify eligibility without asking families for documents, two-thirds (65%) of all beneficiaries experienced paperless, data-based renewal. By contrast, in the states that made the least use of data to assess eligibility before demanding paperwork, just 22% of Medicaid families were renewed based on data matches.

As noted earlier, the number of total Medicaid beneficiaries fell by 16.4% during unwinding. But among the 10 states with the fewest Medicaid losses, enrollment fell by just 7.8% in the median state.[10] If all states had done as well as ten best states, Medicaid enrollment would have fallen by 6.8 million, rather than 14.3 million.

Put simply, more than 7 million people lost Medicaid during unwinding just because they happened to live in the wrong state.

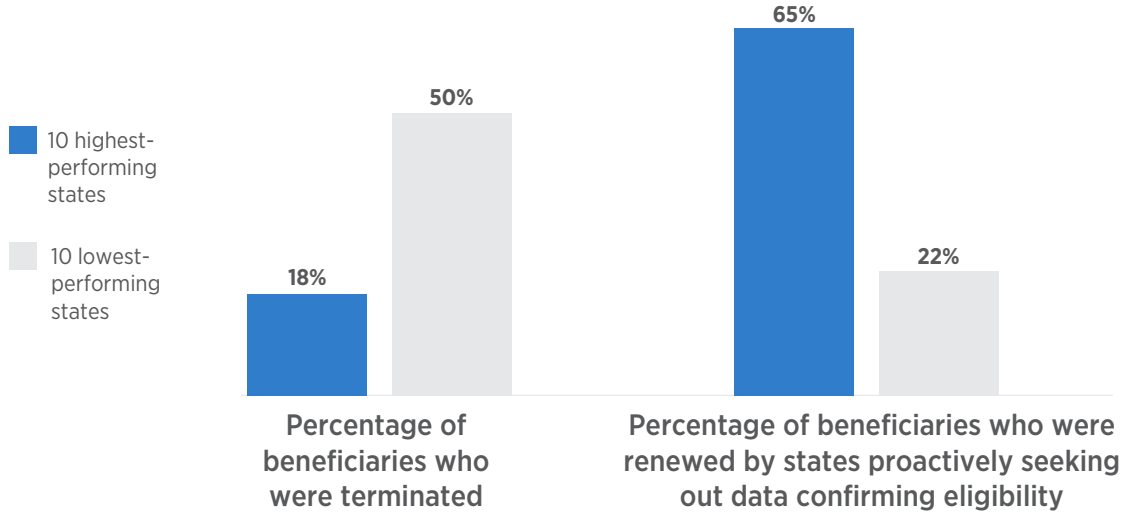
IAP reconstruction must feature strong and enforceable minimum standards of performance that hold IAP agencies accountable for doing the work needed to cover all eligible families.

9 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. If states engage in low mitigation efforts, 10.1 million are estimated to lose coverage.

10 Source: UnidosUS analysis of CMS Medicaid Snapshot Data.

Figure 7. States varied greatly in how much they protected their residents during unwinding

Among the 10 highest- and lowest-performing states, the median percentage of beneficiaries experiencing various outcomes during unwinding



Source: UnidosUS analysis of GAO, June 2025.

Note: The left panel compares the 10 states with the lowest percentages of terminations among all completed redeterminations to the 10 states with the highest such percentages. The right panel compares the 10 states with the highest percentages of data-based renewals among all completed redeterminations to the 10 states with the lowest such percentages. In each comparison, the former states are classified as high performers and the latter as low performers.

3. The underfunding of agency staff and program infrastructure can severely exacerbate administrative burdens.

Ray, Herd and Moynihan made another observation important to understanding IAP vulnerabilities:

> *"It is important to understand strategies that shift power and resources in ways that increase racialized burdens. One such strategy is reducing organizational resources. Such reductions are rarely explicitly justified as a means to facilitate burdens. Instead, they are framed as part of austerity politics or a need for efficiency. But the result is a diminished state where burdens are shifted onto target populations, resulting in longer lines to vote in urban areas, or a dysfunctional welfare application process."*

During unwinding, many states' underinvestment in Medicaid staffing and technological infrastructure significantly increased consumer burdens, costing eligible people their health coverage. For example:

- Underinvestment in Florida's Medicaid call centers led to prolonged wait times that prevented many adults from providing information needed to preserve their families' coverage. During July and August 2023, the average English-language caller waited 36 minutes before reaching a human being. In low-wage jobs, many employees could not take 36-minute breaks to reach the call center before it closed at the end of the business day. But for Spanish-language callers, the barrier to renewal was significantly higher: the wait was nearly 2.5 hours. Even after unwinding ended, this problem remained acute, with 45% of Spanish-language callers getting disconnected before reaching a live agent—nine times the 5% disconnection rate for English-language callers—and wait times that averaged 54 minutes.
- In Texas, employees of the state's Medicaid agency released multiple anonymous "whistleblowers' letters" warning that chronic understaffing and insufficient technology had caused nearly 100,000 people to lose Medicaid by mistake, including thousands of pregnant women, for whom even a brief lapse in healthcare coverage can have catastrophic consequences. According to its own workers, the state's ongoing underinvestment in critical infrastructure caused prolonged and illegal delays in processing applications for both Medicaid and the Supplemental Nutrition Assistance Program (SNAP), the country's main anti-hunger program.

During the assault on IAPs that began in 2025, several federal actions further undermined critical infrastructure in ways that increased families' administrative burdens. For example:

- The Trump administration's elimination of 90% of funding for health insurance Navigators made it harder for families to carry out the administrative tasks needed to enroll and renew health coverage. Families thus face, not just increased administrative burdens, but also fewer resources to manage those burdens.
- With new Medicaid work requirements taking effect in January 2027, states face significant new responsibilities to assess whether low-income adults are working or have health conditions or caretaker responsibilities that excuse them from work requirements. Federal officials have refused to grant state agencies time and flexibility needed to effectively shoulder those duties. This leaves state agencies facing enormous administrative challenges that will lead to Medicaid being wrongfully terminated for many adults. These already daunting administrative challenges recently ballooned when CMS announced the major new limits to state policy options described above, without granting any additional time for states to adjust for the directional shift. This represents a new, federally imposed mismatch between administrative infrastructure of IAPs and families' need for effective and accurate processing of both initial applications and renewals.
- Soon after taking office, the Trump administration prioritized cutting federal employment, including at public health agencies and agencies that administer IAPs. These staff cuts have made it more difficult for states and other stakeholders to obtain the guidance needed to operate family-centered programs. And with basic public health functions compromised through cuts to expert staff, IAPs are deeply hampered in accomplishing their core objective of promoting families' health and well-being.

IAP reconstruction must guarantee sufficient eligibility infrastructure, including both information technology and IAP agency staff.

4. Both high-tech and high-touch approaches have proven effective in preventing administrative burdens from denying health coverage to eligible people.

Data matches to establish eligibility can eliminate families' administrative burdens

Medicaid unwinding included major successes as well as serious problems. From May 2023 through July 2024, aggregate national performance on several key unwinding metrics improved dramatically, despite the above-noted shortcomings in some states. Among all beneficiaries whose renewal was due **(Figure 8)**:

- The national proportion of paperless renewals, based on data,[11] more than doubled, rising from 25% to 55%.
- The proportion of procedural terminations plummeted from 29% to 11%—a relative decline of more than 50%.

Federal support played a powerful role in galvanizing improvement. Such support included:

- Guidance offering numerous options for cutting administrative burdens through waivers under Social Security Act §1902(e)(14)(A).
- Visits from the U.S Digital Service, which provided information technology experts to work intensively with state eligibility staff to overcome challenges and automate renewal procedures.
- Ongoing technical assistance calls between CMS staff and state Medicaid officials.
- Skilled technical assistance offered through independent experts, such as the State Health and Values Strategy program and Manatt Health Consulting.

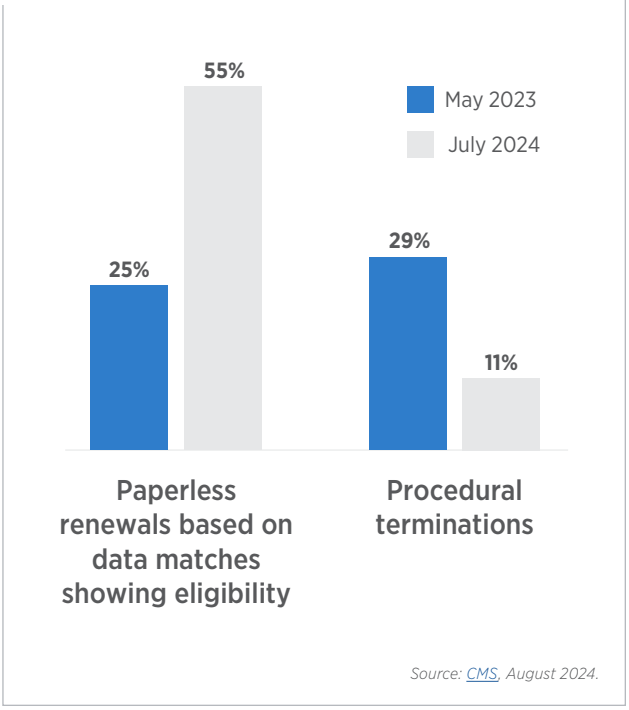
Expert assistance to complete paperwork on families' behalf can preserve healthcare by shifting administrative burdens from families to people better equipped to navigate program complexities

Another remarkable accomplishment during Medicaid unwinding involved people transitioning from Medicaid to ACA coverage offered through the federally operated enrollment platform, healthcare.gov. In theory, people terminated from Medicaid because of increased income

11 Such renewals are often termed, "*ex parte*," meaning that the state seeks out relevant data, finds a beneficiary eligible based on that data and renews their coverage.

Figure 8. States, as a whole, greatly improved their performance over the course of unwinding

Various outcomes as a percentage of beneficiaries due for redetermination: May 2023 vs. July 2024



Source: CMS, August 2024.

should move automatically to Marketplace coverage. In practice, the system for transferring files from state Medicaid agencies to healthcare.gov worked very poorly. Typically, families needed to begin brand-new applications for Marketplace coverage—a step that prevented many households from making the transition.

Federal officials realized that there wasn't time to fix the file transfer process before unwinding. Instead, they developed an intensive outreach and consumer assistance campaign through which navigators and other application assisters contacted consumers losing Medicaid and helped them transition to Marketplace coverage. This results were remarkable: Over the course of Medicaid unwinding, 3 million consumers successfully moved from Medicaid or CHIP to health coverage offered through the healthcare.gov Marketplace.

It is feasible and therefore imperative for IAP reconstruction to protect families' coverage through both data-driven, seamless eligibility and hands-on assistance from knowledgeable human beings.

5. Neither federal agencies nor the courts are fully reliable protectors of historically marginalized communities.

Federal agencies may lack the capacity or will needed to protect marginalized communities. This can leave families without recourse, given judicially imposed restrictions on holding state agencies accountable in court.

Federal agencies face significant limitations in protecting vulnerable communities

Both during recent events and in the longstanding history of IAPs, many factors have often left members of historically marginalized communities without sufficient protection from federal agencies. Those factors, which can vary greatly by administration, include:

- **Opposition to the interests of historically marginalized communities**. During the current administration, policy preferences have led to many choices that damage health coverage and healthcare access for people of color: the reclassification of DACA immigrants to make them ineligible for ACA coverage; the promulgation of ACA regulations that raise consumer costs and needlessly increase families' administrative burdens; the repeal of Biden administration Medicaid regulations that streamlined enrollment and renewal; and the proposal of unprecedented immigration status limits on community health center care and other services funded through discretionary federal grants.
- **Insufficient resources**. During the Biden administration, the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) received a number of complaints about state policies that had the effect of discriminating based on race and ethnicity, in violation of Title VI of the Civil Rights Act of 1964 and ACA Section 1517. OCR sometimes lacked the resources needed to vigorously pursue those complaints. As a result, some states were able to continue discriminatory policies, largely unchecked by OCR.
- **Variable willingness to depart from past practice**. During the Biden administration, CMS officials were sometimes initially reluctant to provide states with requested flexibilities needed to preserve eligible families' coverage. In one notable example, several years of effort by consumer advocates and industry were needed to secure a change in policy letting Medicaid managed care organizations (MCOs) complete paperwork to prevent the wrongful termination of MCO members. By contrast, the Trump administration has moved with remarkable speed to ignore past precedent and deny federal matching funds to states like Minnesota, California and New York, based on unsupported charges of Medicaid fraud.
- **A willingness to be aggressive in enforcement that varies by administration**. During the Biden administration, CMS sometimes appeared reluctant to take enforcement action against states unless a completely unambiguous statute or regulation was being violated. CMS thus took vigorous action restoring numerous children's wrongfully terminated coverage when states mistakenly determined eligibility at the household rather than the individual level. On the other hand, CMS did not require states to meet any minimum numerical requirements for data-based renewals or maximum permitted procedural terminations, despite potential justifications for such steps. CMS also refused to defer payment of federal matching funds, pending improvements in state performance. Officials may have feared that, without inarguable violations of clear legislative or regulatory standards, states could avoid accountability by filing lawsuits in judicial districts whose judges were reluctant to support federal policy positions. The reasonable concern that bad law could result, both in the district court and federal circuit courts, may have deterred CMS from taking vigorous enforcement actions against states that were particularly extreme in denying families health coverage. By contrast, the Trump administration has aggressively levied significant federal denials and deferrals of matching funds based on generalized and unsubstantiated allegations about waste, fraud and abuse.

Families are often denied the ability to obtain judicial relief compelling IAP agencies to follow the law

In recent decades, the U.S. Supreme Court has increasingly narrowed the options for families in historically marginalized communities to hold officials accountable for lawbreaking. As a result, families are often without judicial recourse. Two key developments stand out:

1. **Families can rarely obtain court orders requiring state agencies to follow Medicaid law**. A 2025 Supreme Court decision forbade lower courts from hearing beneficiaries' arguments that a state's exclusion of Planned Parenthood from Medicaid violated the federal Medicaid statute. According to the Court, families have no ability to compel legal compliance except to vindicate a statutory standard that meets a "stringent" and "demanding" test of "clearly and unambiguously using rights-creating terms." Even then, according to the Court, unless Congress legislates with

crystalline clarity, beneficiaries can be denied the right to sue if CMS has remedies that, in theory, can address state misbehavior.

2. **When a state agency or other entity receives federal funds, statutory prohibitions of discrimination based on race or ethnicity under Title VI of the Civil Rights Act of 1964, ACA Section 1517 and similar statutes cannot be enforced in court without proof of discriminatory intent**. The Supreme Court has left the door open for administrative agencies to take enforcement action against seemingly neutral practices that cause disproportionate and unjustified harm to particular racial and ethnic groups. However, without a "smoking gun" proving discriminatory intent, injured individuals may not bring suit based on disparate impact, no matter how intensely the harmful results single out people of color.

IAP reconstruction must provide strong, new mechanisms for holding agencies accountable for protecting eligible families' coverage and care.

6. Immigrant scapegoating, rhetoric with racist undertones and allegations of fraud and abuse have been used to excuse wide-ranging attacks on healthcare for low-wage working families from communities of color.

In 2022, Ray, Herd and Moynihan noted the role of bad faith justifications in legitimating policies that disproportionately harm members of historically marginalized communities:

> *A "more frequent type of justification" uses "claims about fraud or illegality, or lack of deservingness in some way," making arguments that are "not explicitly racial but [rely] on coded language that plays upon macro-level stereotypes."*

Three such justifications emerged during recent attacks on IAPs:

1. **Members of Congress and the administration** terminated numerous lawfully present immigrants, falsely claiming they were undocumented immigrants**.** Through a combination of OBBBA and regulations, Congress and the Trump administration have limited eligibility for Medicaid, Medicare, ACA health coverage and the Children's Health Insurance Program to green card holders, Cuban and Haitian immigrants, and citizens of certain Micronesian nations. Nearly 1.5 million lawfully present immigrants living in the United States with the knowledge and permission of the federal government—including refugees; asylees; people fleeing violence, persecution, or domestic violence; as well as DACA holders brought to this country as children who have known no other home—have lost health coverage. Also terminated from ACA health coverage were green card holders with incomes below the federal poverty level who are ineligible for Medicaid because their lawful immigration status was approved within the past five years.

2. **Racist stereotypes undergird the campaign to terminate Medicaid for expansion adults who neither document work nor prove they cannot work** because of health problems or caretaker responsibilities. As explained by Cornell University scholars Brady and Wiggs, "To justify work requirements..., the public-facing reasoning has been premised on a set of assumptions, racist in origin and nature, that benefit recipients are lazy and do not want to work." In truth, the vast majority of adults subject to Medicaid work requirements are already employed; and most people terminated because they supposedly violated

work requirements in fact were either employed or exempt from work requirements but lost coverage anyway because they did not meet state documentation requirements.

3. **Unsupported and misleading claims about waste, fraud and abuse** have been used to advocate for letting EPTCs expire after 2025, to excuse the above-described withholding of significant federal funding to states headed by Democratic governors, and to support a furious attack on Medicaid coverage of home- and community-based services. In fact, these blanket cuts to IAPs don't target fraud, but instead punish eligible vulnerable populations who did nothing wrong.

IAP reconstruction should incorporate features that undermine the credibility of misleading accusations of beneficiary fraud and misconduct.

7. Longstanding administrative policies that have enjoyed bipartisan support can be vulnerable to repeal unless they are embodied in clear statutory requirements.

Less than 18 months into President Trump's second term, the administration has repealed many longstanding regulations and sub-regulatory policies that had clear bipartisan support and seemed stable and secure. Because these policies were not embedded in statute, however, they proved vulnerable and were repealed. Examples include:

- A "sensitive locations" policy prohibiting immigration enforcement at healthcare provider sites, as well as schools, places of worship and social services agencies.
- The absence of immigration status limits on services funded through discretionary federal grants, including community health center care and treatment of severe mental health and substance use disorders.
- Administrative agencies' authority, without requiring proof of discriminatory intent, to hold recipients of federal funding accountable for actions that cause disproportionate harm to people of color.

Whenever possible, IAP reconstruction should clearly set out crucial safeguards in statutes, rather than leave them to administrative policy alone.

A Civil Rights Agenda for Reconstructing Insurance Affordability Programs

Federal policymakers must reverse the past two years' worth of healthcare cuts, which have harmed Americans from all backgrounds, with especially grave damage experienced in communities of color. But if policymakers do no more than return to past health coverage arrangements, they will waste an opportunity to achieve major gains in equity and health-care justice. Windows for achieving significant national progress can quickly close. When the next window opens, federal policymakers must take full advantage of what may be a time-limited opportunity for change and reconstruct IAPs to do a much better job of serving the communities that rely on them for health coverage. We urge three crucial steps as top priorities: (1) making IAPs substantially more seamless and paperless for families; (2) making IAPs fully accountable to the communities they serve; and (3) treating all families fairly, regardless of race, ethnicity and their state of residence.

Making IAPs substantially more seamless and paperless

Five policy changes are needed to make IAPs significantly less burdensome for families:

1. Eligibility pathways should be redefined so many more people qualify based on data available to state officials, without any need to provide documentation.

As is already true for college student aid and means-tested premiums for Medicare Parts B and D, people should qualify for a minimum, guaranteed level of health coverage based on prior-year tax returns. If income has fallen since the year covered by the return, people should be able to demonstrate increased need, but prior-year tax records should guarantee a minimum level of health coverage.

Further, people who benefit from SNAP have already proven low income as well as either citizenship or satisfactory immigration status. They should automatically qualify for Medicaid, without denying health coverage until state officials have wasted valuable public resources reexamining the same basic questions that were already resolved by the SNAP program.[12]

Those two steps alone would enable data-based renewal for the vast majority of Medicaid beneficiaries. Among people of all races and ethnicities, 80% or more of Medicaid beneficiaries in 2025 either filed federal income tax returns, were included as dependents on federal income tax returns or participated in SNAP **(Figure 9)**.

Automatically basing eligibility on prior-year income tax returns and SNAP participation would also help qualify the vast majority of uninsured people for Medicaid or ACA coverage. More than 80% of people without insurance in 2025 either participated in SNAP or were included on federal income tax returns, including at least 75% of people in each racial or ethnic group **(Figure 10)**.

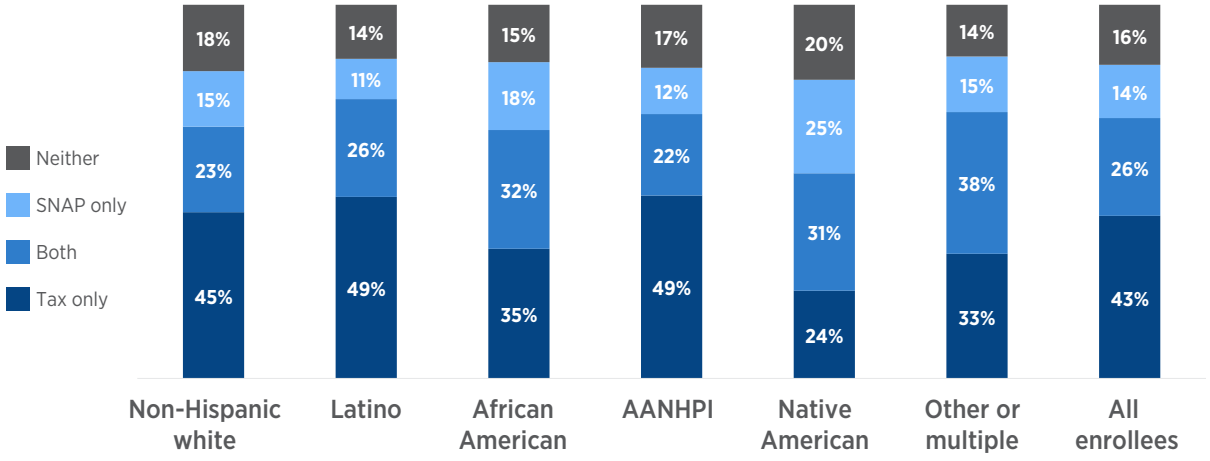
Other programs have used this approach, with great success. As already outlined, prior-year federal income tax returns establish minimum, guaranteed eligibility for college student aid and means-tested premiums for Medicare Parts B and D. And nutrition programs have long addressed the urgency of hunger by immediately granting "categorical" eligibility for SNAP based on participation in other programs and by finding pregnant and postpartum women and young children "adjunctively" eligible for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) based on Medicaid eligibility. Here are other examples of policymakers achieving significant gains by redefining eligibility for need-based assistance to fit available data:

- Without documenting income or assets, older adults and people with disabilities automatically qualify for Medicare Part D low-income subsidies (LIS) of prescription drug coverage if they have been found eligible for Medicaid, state subsidies of Medicare Part B premiums, or Supplemental Security Income. After receiving a notice, they are automatically enrolled in Part D with

12 This approach would disregard the relatively minor technical differences between how SNAP and Medicaid define households and calculate income. Altogether, Medicaid's eligibility requirements are fully met for 97% of SNAP participants who are either children or adults under age 65 who live in Medicaid expansion states.

Figure 9. Among Medicaid beneficiaries of all races and ethnicities, the vast majority are included on federal income tax returns or participate in SNAP

Medicaid enrollees, by tax filing status, SNAP participation, race and ethnicity: 2025

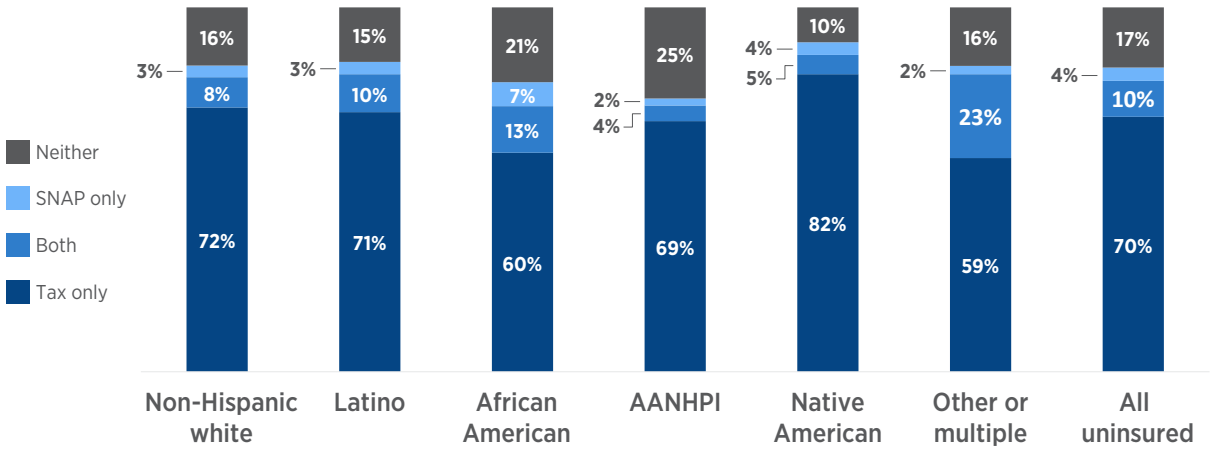


Source: UnidosUS analysis of March 2025 Current Population Survey-Annual Social and Economic Supplement (CPS-ASEC), accessed through IPUMS.

Notes: Latinos are Hispanics of all races. All other racial and ethnic classifications are limited to non-Hispanics. AANHPI = Asian American, Native Hawaiian and Pacific Islander. Tax filers include people estimated by CPS-ASEC as filing federal income tax returns or benefiting from Earned Income Tax Credits (EITCs) on federal income tax returns.

Figure 10. Among uninsured people of all races and ethnicities, the vast majority are included on federal income tax returns or participate in SNAP

Uninsured people, by tax filing status, SNAP participation, race and ethnicity: 2025



Source: UnidosUS analysis of March 2025 CPS-ASEC data, accessed through IPUMS.

Notes: Latinos are Hispanics of all races. All other racial and ethnic classifications are limited to non-Hispanics. AANHPI = Asian American, Native Hawaiian and Pacific Islander. Tax filers include people estimated by CPS-ASEC as filing federal income tax returns or benefiting from EITCs on federal income tax returns.

LIS unless they opt out. In 2023, **91% of all Medicare LIS beneficiaries qualified for assistance automatically, based on their participation in other programs, without any need to complete application forms**.[13]

- Through Express Lane Eligibility (ELE), states have the option to qualify children for Medicaid based on the findings of other need-based programs, including SNAP. Before ACA's passage, two states (South Carolina and Louisiana) automatically enrolled children into Medicaid based on their SNAP participation, unless their parents opted out.[14] In South Carolina, nearly 100,000 children received health coverage in just nine months; and in Louisiana, ELE caused a major drop, from 5.3 percent to 2.9 percent, in the percentage of Medicaid-eligible children who lacked health coverage.

Several guardrails are important for these new pathways to work effectively:

- They would supplement rather than replace current pathways. Nothing would prevent someone from qualifying for IAPs without filing a tax return or applying for SNAP.
- Data matches could not, by themselves, lead to termination or denial of an application. If data does not confirm eligibility, families must be given the opportunity to document eligibility manually. And before denying an application or terminating coverage, IAPs are obliged, both under the 14th Amendment to the U.S. Constitution and applicable statutes, to provide advance notice and a chance to appeal the adverse action.
- It is imperative to establish strong safeguards protecting data privacy and security, including the prevention of sharing personally identifiable data with any immigration enforcement agency.

Creating these alternative pathways to IAP eligibility would offer important advantages, in addition to eliminating paperwork burdens for most eligible families. The new pathways would:

- **Shield IAPs and families from unfounded claims of waste, fraud and abuse**. With new eligibility categories defined to fit available data, data that qualifies someone for coverage effectively makes eligibility certain.
- **Protect people in ACA coverage from federal income tax liability.** Currently, under OBBBA, a family claiming advance premium tax credits (APTCs) that turn out

to exceed the amount for which they qualify based on federal income tax returns filed the following year must repay the excess credits—even if the family made an innocent mistake or the error resulted entirely from actions taken by the Marketplace, the insurance carrier or a broker. Enormous federal tax penalties will hit consumers, including those who did nothing wrong, starting when 2026 tax returns are filed in 2027. But if APTC amounts were redefined based on prior-year income tax returns, as we propose, then PTC eligibility would typically be unaffected by events during the plan year, which would shield families from unexpected and significant tax penalties.

- **Enable streamlined enrollment of the eligible uninsured into both Medicaid and zero-net-premium Marketplace coverage.** Once someone is known to qualify for such coverage, based on available data, they could be given notice and enrolled unless they opt out, subject to important safeguards that ensure informed consent. With eligibility defined based on available data, such enrollment would not subject them to later penalty or sanction, because their eligibility would be essentially certain.

13 UnidosUS analysis of CMS, MDCR ENROLL D 2, Medicare Part D Enrollment: Part D Enrollees by Type of Plan, Low Income Subsidy (LIS), and Retiree Drug Subsidy, by Demographic Characteristics, Calendar Year 2023.

14 Technically, these two states met the statutory requirement for parental consent by informing parents that they could show consent through using their children's Medicaid coverage to seek healthcare, without completing paperwork. In addition, parents could opt out of data sharing before their children's ELE eligibility was assessed.

2. 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.

In 11 states and the District of Columbia, a single eligibility system determines eligibility for all IAPs. In such states, someone who applies at one program and qualifies for another is automatically certified as eligible for the latter and enrolled. Similarly, if a change in family circumstances means that someone enrolled in one program becomes ineligible for that program but now qualifies for a second program, the person can be moved from one program to the other, without being asked to complete redundant paperwork.

Most other states have far more fragmented eligibility methods. If a person applies to one program but qualifies for another, or a person is terminated from one program and qualifies for another, the first program sends their file to the second program, which makes its own eligibility assessment. Despite regulations to the contrary, the person is often unable to obtain coverage without giving the second program information already given to the first or even completing a brand-new and entirely redundant application form.

This disconnect between Medicaid and ACA programs in the latter, so-called "assessment and file transfer states"—and the resulting increases in administrative burdens—cause significant losses. Researchers found that the ACA's early coverage gains were more than one-third lower for parents and nearly 50% lower for children in states that operated assessment and file transfer systems, compared to states with integrated eligibility systems. Other researchers found that people with limited English proficiency suffered the greatest coverage losses, and that children who were Black, Latino or from other communities of color were at heightened risk.

To prevent families from being denied health coverage due to fragmented eligibility systems, states should be given the option to either operate a single eligibility system for all IAPs or have each IAP provide coverage based on the determinations of other IAPs.[15]

3. Agencies administering IAPs should be required to meet standards that minimize administrative burdens, while simultaneously receiving sufficient funding to invest in necessary technology and staff.

Such funding includes the resources to establish integrated eligibility systems that serve all IAPs within a state. Agencies administering programs like Medicaid and SNAP have long been legally obliged to process applications within specified time periods. Quantitative standards should also govern other key eligibility outcomes, forbidding excessive rates of procedural terminations or denials as well as unjustifiably low rates of data-based eligibility determination.[16]

Consequences when IAP agencies fail to comply with these standards should not be limited to drastic penalties, such as the denial of massive amounts of federal Medicaid funding, that often lack credibility because they are unlikely to be levied by administrations supportive of the Medicaid program's core goals. Rather, consequences should be structured to protect the families who rely on these programs without undermining IAP functionality. For example:

- If a state Medicaid program fails to meet targets applicable to redeterminations, procedural terminations should immediately halt until the state hits those targets.
- If a state Medicaid program fails to meet targets applicable to initial applications, then until it has come into compliance, the program should be forbidden from denying eligibility for purely procedural reasons and should instead be required to provide interim coverage pending final eligibility determinations.
- CMS should be authorized to delay or deny payment of federal matching funds when states violate these standards. To prevent states from benefiting financially from federal legal violations, the amount of federal funds that are deferred or denied could be based on the state's savings from reducing its caseload by violating applicable standards.

15 The latter approach is already used in eight states that are classified as "determination" rather than "assessment" states. See Appendix Table 7, Integration of MAGI-Medicaid Eligibility System with Marketplace Eligibility System, Non-MAGI Medicaid, and Non-Health Programs, January 2026, Georgetown Center for Children and Families and KFF, April 30, 2026.

16 Statutes or regulations could define the maximum permitted percentage of Medicaid redeterminations that result in procedural termination; the minimum percentage of Medicaid redeterminations that result in renewals based on data matches, without any request for families to provide information; the maximum permitted percentage of IAP applications that are denied for procedural reasons; the minimum percentage of IAP applications that are verified entirely based on data matches, without a request for applicant documents; and the minimum percentage of calls to IAP call centers that are answered within a specified number of minutes, assessed based on independently verified "secret shopper" calls rather than vendor or IAP agency self-reports.

For IAPs to provide high-level customer service, they need resources to hire staff and invest in information technology. Such investments in IAP infrastructure hold little political appeal and are difficult to sustain. To the maximum extent possible, they should become mandatory expenditures on which IAP agencies can rely on in planning for the future.

4. Funding for independent consumer assistance should be guaranteed, whether through mandatory federal allotments or a minimum proportion of fees charged to insurers offering IAP coverage.

Public funding sources should be supplemented through insurer engagement, based on approaches permitted during Medicaid unwinding as well as New York State's longstanding waiver program allowing Medicaid MCOs to help with enrollment and renewal, subject to strong guardrails limiting self-dealing and conflicts of interest.

5. When adults qualify for Medicaid, they should obtain 12 months of continuous coverage, as is already true for children.

In addition to reducing the frequency of redetermination and associated administrative burdens, coverage that is continuous rather than episodic yields improved health outcomes. States should also have the option, without seeking federal waivers, to guarantee continuous coverage for longer than 12 months. For example, states should be allowed to provide at least five years of continuous and guaranteed Medicaid coverage for children born into low-income families, as many children's advocates have already proposed.

Making IAPs more accountable to the communities they serve

Several steps are needed to promote accountability:

1. **People eligible for IAPs should be authorized to seek judicial orders remedying legal violations that undermine access to coverage or care.** Given the above-noted U.S. Supreme Court resistance to such enforcement, legislation granting the right to judicial enforcement must be drafted with great care.
2. **When recipients of federal funds, including IAP agencies, take actions that cause disproportionate and unjustified harm based on race and ethnicity, aggrieved individuals should be able to bring suit to stop such actions.** Proof of discriminatory intent should not be required for harmed individuals to prevail in court.
3. **CMS must be able to hold agencies administering IAPs accountable to protect beneficiaries without such agencies filing litigation in carefully selected courts that are reluctant to allow enforcement.** As one possible remedy, the District of Columbia could be the exclusive venue for lawsuits seeking to stop CMS from enforcing beneficiary protections that limit costs, protect benefits or access to care, or prevent denials, terminations or delays of coverage.

Treating all IAP families fairly, including people from historically marginalized communities and people living in non-expansion states

Several policy changes are needed to ensure that essential and affordable health coverage is available to all in need:

1. **People with incomes below the federal poverty level should not be denied health coverage because they live in a state that still refuses to expand Medicaid, more than 16 years following the ACA's enactment.** In these states, adults should qualify for Marketplace health coverage, with additional financial assistance and benefit guarantees needed to ensure affordable coverage and care no less generous than that offered by Medicaid.[17]

2. **Immigrants who pay federal and state taxes and contribute to their communities should have access to health coverage,** in several ways:

   - Lawfully present immigrants, who live in the United States with the knowledge and permission of the federal government, should not be denied IAP eligibility based on immigration status.
   - No one should be forbidden, based on immigration status, from using their own money to purchase health insurance through ACA Marketplaces.
   - States and localities should have the flexibility to cover all of their residents in need, without discrimination based on immigration status.[18]

3. **Federal statutes should guarantee immigrants the right to seek health coverage for which they qualify, without endangering future improvements to their families' immigration status.** In-kind benefits other than long-term services and supports should not count in determining whether someone is likely to become a public charge. Such clear, bright-line rules that remain in effect regardless of administration are needed for people to plan their lives.

Next steps toward implementing this agenda

First, whenever possible, states and localities should test the real-world effects of policies like those recommended here. The scope for state and local innovation may be limited in the near term. It is hard to envision the Trump administration granting waivers under Section 1115 of the Social Security Act to allow expanded coverage of immigrants, for example, or to permit major streamlining of Medicaid eligibility determinations. But some policies may be possible for states and localities to implement on their own, such as the creation of private rights of action under state law for aggrieved individuals to remedy practices that cause disparate and unjustified harm to people based on race and ethnicity.

Second, advocates should build broad national consensus around proposals like those discussed here. These ideas must be pressure-tested by engaging community organizations and families who bring their lived experience to bear. In addition, state and national stakeholders, policy experts, and current and former federal officials need to be part of a conversation around how IAPs should be reconstructed to better serve historically marginalized communities.

Third, an agenda for national action must plan for contingencies. The future balance of power is, by definition, uncertain. In addition to a congressionally focused action plan, advocates should be prepared with a menu of policy remedies that can be implemented exclusively through aggressive use of Executive Branch authority.

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17 In theory, the federal government could operate a special Medicaid program in these states. But the required creation of entirely new administrative infrastructure is likely to take considerable time and pose risks of poor initial service, as illustrated by the public failures of many states' ACA marketplaces when they began operation in 2014.

18 States should have the option to use their own resources to cover residents in need, without discrimination based on immigration status. In addition, states should receive federal Medicaid match if they opt to cover all residents within defined categories, such as children or older adults who are financially eligible for Medicaid or CHIP. Moreover, states or localities should be allowed to cover all residents without requiring application forms, claiming federal match based on the characteristics of 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 demonstrating the proportion of enrollees who qualified for federally matched coverage. 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). This approach would cover all otherwise uninsured residents, claiming federal match for eligible people based on retrospective sampling, without denying healthcare until community members complete application forms.

Conclusion

Recent years have been very difficult for millions of families who rely on Insurance Affordability Programs (IAPs) for healthcare access and protection from unaffordable medical bills.

Facing the historic challenge of redetermining Medicaid eligibility for 90 million Americans during the unwinding, federal officials did extraordinary work to preserve eligible people's coverage, as did officials in many states. But federal agencies faced limitations in what they could do, and some states fell far below their peers in preserving eligible families' coverage, especially in historically marginalized communities. The end of Medicaid unwinding was soon followed by the enactment of legislation making history's largest cuts to federal health programs, accompanied by a raft of administrative policies that hurt Americans from all backgrounds but disproportionately target people of color. Families have already experienced significant harm, but many of the worst cuts do not take effect until 2027.

These dark times will not last forever, and they teach important lessons. Once the national political environment becomes more receptive to bold measures that dramatically expand health insurance coverage to reach millions of additional families, it will become imperative for policymakers to both reverse recent cuts and embrace the wholesale reconstruction of IAPs.

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